



## INDIANA HEALTH COVERAGE PROGRAMS

### PROVIDER REFERENCE MODULE

# Member Eligibility and Benefit Coverage

LIBRARY REFERENCE NUMBER: PROMOD00009  
PUBLISHED: MAY 14, 2020  
POLICIES AND PROCEDURES AS OF APRIL 1, 2019  
VERSION: 4.0



## Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: July 19, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of September 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: June 20, 2017	Scheduled update	FSSA and HPE
3.0	Policies and procedures as of March 1, 2018 Published: October 2, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of April 1, 2019 Published: May 14, 2020	Scheduled update: <ul style="list-style-type: none"> <li>• Reorganized and edited text as needed for clarity</li> <li>• Added initial note box with standard wording</li> <li>• Updated links to the IHCP website</li> <li>• Removed HIP Employer Link and PRTF Transition Waiver references</li> <li>• Updated the <a href="#">IHCP Programs and Benefit Plans</a> section</li> <li>• Added note about IEDSS replacing ICES in the <a href="#">Member Identification</a> section</li> <li>• Updated sample cards in the <a href="#">Healthy Indiana Plan Member Card</a> section</li> <li>• Added a note about Hoosier Healthwise logo update and removed sample cards with the old logo in the <a href="#">Hoosier Healthwise Member Card</a> section</li> <li>• Removed <i>MCE Health Plan Eligibility</i> section</li> <li>• Added a note box about future dates in the <a href="#">Verifying Eligibility for a Specific Date of Service</a> section</li> <li>• Added the <a href="#">Eligibility Verification on the Portal</a> section and subsections</li> </ul>	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> <li>Added a note about the Emergency Services Only with Pregnancy Services (Package B) benefit plan to <a href="#">Section 2: Fee-for-Service Programs and Benefits</a></li> <li>Updated the list of eligible groups in the <a href="#">Traditional Medicaid</a> section</li> <li>Clarified in the <a href="#">HCBS and ESRD Waiver Liability</a> section when a provider can bill a member for amounts credited to liability</li> <li>Added the <a href="#">Benefit Limits and Waiver Liability</a> section</li> <li>Made clarifications to the descriptions and notes in <a href="#">Table 2 – Medicare Savings Program Coverage Categories</a></li> <li>Updated the <a href="#">Eligibility Verification for OMB-Also and SLMB-Also Members with Liability</a> section</li> <li>Updated the <a href="#">Emergency Services Only – Package E</a> section</li> <li>Updated the <a href="#">Fee-for-Service Benefit Options</a> section</li> <li>Replaced list of eligible provider types with a reference to the <i>Provider Enrollment</i> module in the <a href="#">Primary Medical Providers</a> section</li> <li>Clarified information about psychiatric services in the <a href="#">Self-Referral Services</a> section</li> <li>Updated the <a href="#">Healthy Indiana Plan</a> section and subsections</li> <li>Updated the <a href="#">Hoosier Care Connect</a> section</li> <li>Updated the Hoosier Healthwise <a href="#">Package A</a> section</li> <li>Updated the Package C <a href="#">Enrollment Process and Cost-Sharing Requirements</a> section</li> <li>Updated <a href="#">Table 8 – Comparing Hoosier Healthwise Benefit Packages A and C</a></li> <li>Updated the <a href="#">General Requirements for Presumptive Eligibility</a> section</li> </ul>	

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> <li>Updated the <a href="#"><i>Presumptive Eligibility Aid Categories and Benefit Plans</i></a> section to reflect all PE plans are now fee-for-service</li> <li>Added the <a href="#"><i>Portal Copayment Response</i></a> section</li> <li>Added <a href="#"><i>Section 6: Benefit Limit Information</i></a></li> <li>Updated the introduction to <a href="#"><i>Section 7: Retroactive Member Eligibility</i></a></li> <li>Added the <a href="#"><i>Retroactive Eligibility for Managed Care Members</i></a> section</li> <li>Updated the <a href="#"><i>Limited Retroactive Eligibility for Hoosier Healthwise Package C Members</i></a> section</li> <li>Updated the <a href="#"><i>Provider Responsibilities for Retroactive Eligibility</i></a> section</li> <li>Updated the introductory text in <a href="#"><i>Section 8: Member Appeals</i></a></li> </ul>	



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## Section 1: Member Eligibility Overview

*Note: For updates to the information in this module, see [IHCP Banner Pages and Bulletins](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

The Family and Social Services Administration (FSSA) offers a number of different programs and services under the Indiana Health Coverage Programs (IHCP) umbrella. Program and service options are available to Hoosiers based on established eligibility criteria.

Providers should advise people interested in applying for IHCP benefits to submit an *Indiana Application for Health Coverage* using any of the following options:

- Apply online through the [FSSA Benefits Portal](#).
- Apply by telephone by calling the Division of Family Resources (DFR) call center at 1-800-403-0864.
- Apply in person at their [local DFR office](#).

Member eligibility for the 590 Program is initiated by the institution where the member resides. The FSSA provides general information about program eligibility and application on the [IHCP member website](#) at [in.gov/medicaid/members](http://in.gov/medicaid/members).

The IHCP reimburses participating providers for necessary and reasonable medical services provided to individuals who are enrolled in the IHCP and who are eligible for the benefit at the time service is provided. The member is free to select the provider of services, unless the member is restricted to a specific provider through the Right Choices Program (RCP) or through a managed care program.

## IHCP Programs and Benefit Plans

Generally, IHCP members receive benefits under either the fee-for-service (FFS) delivery system or the managed care delivery system, depending on which program they are enrolled in. However, certain services and benefit options cross over delivery systems and are delivered as FFS for *all* eligible members, including members enrolled under a managed care program.

IHCP programs and services are delivered as follows:

- FFS programs and services are delivered by enrolled IHCP providers and reimbursed directly through the IHCP fiscal agent, DXC Technology, or by the FFS pharmacy benefit manager, OptumRx. See the [Fee-for-Service Programs and Benefits](#) section of this module for information about FFS programs as well as certain benefit options that are delivered as FFS regardless of whether the member is enrolled in an FFS or managed care program.
- Managed care programs and services are delivered by enrolled IHCP providers that participate in managed care networks. Services are reimbursed by managed care entities (MCEs) contracted by the State to manage the care for their members, or by subcontractors of the MCEs. See the [Managed Care Programs](#) section of this module for information about the IHCP managed care programs and benefit plans.

See the [Special Programs and Processes](#) section of this module for information about special programs and processes, including coverage for presumptively eligible individuals as well as information about the Right Choices Program.

[Table 1](#) lists the specific IHCP benefit plans associated with each program, benefit option, or special process.

Table 1 – IHCP Programs and Associated Benefit Plans

Fee-for-Service Program	Benefit Plan Name
Traditional Medicaid	Full Medicaid* <i>* With no managed care program assignment (Fee-for-service plus nonemergency medical transportation [NEMT])</i>
	Package A – Standard Plan* <i>* With no managed care program assignment (Fee-for-service plus NEMT)</i>
Medicare Savings Programs	Qualified Disabled Working Individual
	Qualified Individual
	Qualified Medicare Beneficiary
	Specified Low Income Medicare Beneficiary
Emergency Services Only**	Package E – Emergency Services Only
Family Planning Eligibility Program	Family Planning Eligibility Program
590 Program	590 Program
Managed Care Program	Benefit Plan Name
Healthy Indiana Plan	HIP Basic
	HIP Plus
	HIP State Plan Basic
	HIP State Plan Plus
	HIP State Plan Plus Copay
	HIP Maternity
Hoosier Care Connect	Full Medicaid* <i>* With Hoosier Care Connect managed care program assignment</i>
	Package A – Standard Plan* <i>* With Hoosier Care Connect managed care program assignment</i>
Hoosier Healthwise	Package A – Standard Plan* <i>* With Hoosier Healthwise managed care program assignment</i>
	Package C – Children’s Health Plan (SCHIP)
Program of All-Inclusive Care for the Elderly (PACE)	Program of All-Inclusive Care for the Elderly
Benefit Option (Fee-for-Service)	Benefit Plan Name
1915(i) State Plan Home and Community-Based Services (HCBS)	Adult Mental Health Habilitation
	Children’s Mental Health Wraparound
	Behavioral & Primary Healthcare Coordination
1915(c) HCBS Waiver	Aged and Disabled HCBS Waiver
	Community Integration and Habilitation HCBS Waiver
	Family Supports HCBS Waiver
	Traumatic Brain Injury HCBS Waiver
Money Follows the Person (MFP) Demonstration Grant	MFP Traumatic Brain Injury
	MFP Demonstration Grant HCBS Waiver [Aged and Disabled]
Medicaid Rehabilitation Option (MRO)	Medicaid Rehabilitation Option

Special Program or Process	Benefit Plan Name
Presumptive Eligibility	Presumptive Eligibility – Adult
	Presumptive Eligibility Family Planning Services Only
	Presumptive Eligibility – Package A Standard Plan
	Presumptive Eligibility for Pregnant Women
	Medicaid Inpatient Hospital Services Only [PE for Inmates]
Medical Review Team (MRT)	Medical Review Team
Preadmission Screening and Resident Review (PASRR)	PASRR Individuals with Intellectual Disability
	PASRR Mental Illness (MI)
<p><i>Notes:</i></p> <p>* <b>Full Medicaid and Package A – Standard Plan</b> offer the same level of benefits.</p> <p>** Effective November 30, 2019, the IHCP added a new FFS Emergency Services Only (ESO) benefit plan called <b>ESO Coverage with Pregnancy Coverage</b> (also referred to as Package B).</p>	

## Member Identification

Each IHCP member is issued a 12-digit identification number that is referred to as the Member ID (also known as RID). The Member ID is assigned by the FSSA DFR through the automated Indiana Client Eligibility System (ICES). Each member also receives a member identification card. The type of card received depends on the IHCP program in which the member is enrolled.

*Note: The Indiana Eligibility Determination and Services System (IEDSS) is replacing the ICES in a phased rollout process. The FSSA Benefits Portal will appear the same to members and authorized representatives. However, members with fully open cases will be receiving a new case number when their cases convert through IEDSS. Providers will not notice a change on the eligibility options used to verify member eligibility, described in the [Eligibility Verification System](#) section.*

### Hoosier Health Card

The IHCP member identification card, called the *Hoosier Health Card*, is used to identify enrollment in IHCP FFS programs, including Traditional Medicaid, Emergency Services Only, Medicare Savings Programs, and the Family Planning Eligibility Program. Each family member covered by the IHCP receives an ID card specific to that member. The front of the Hoosier Health Card contains the following information about the member (as shown in [Figure 1](#)):

- IHCP Member ID
- Name
- Date of birth
- Gender

Figure 1 – Hoosier Health Card



Hoosier Health Cards are issued upon program enrollment. After the DFR determines eligibility, cards are then generated and mailed within 5 business days of the action updating the IHCP Core Medicaid Management Information System (*CoreMMIS*). The member must allow 5 business days plus mailing time to receive the card. A letter to inform the member of eligibility status is system-generated within 24 hours of eligibility determination.

The card is a permanent plastic identification card the member is expected to retain for his or her lifetime. Members should retain their cards even if eligibility lapses, in case eligibility is reinstated at a later date. Members may contact their local DFR county office or call toll-free 1-800-403-0864 to request a replacement Hoosier Health Card.

Cards are not available at the local DFR county offices. Providers may photocopy cards.

### Healthy Indiana Plan Member Card

HIP members receive member ID cards from their individual MCEs: Anthem, CareSource, Managed Health Services (MHS), or MDwise. Examples of HIP cards are provided in Figures 2 through 6. Member identification numbers are located in the indicated areas on the HIP cards shown in the figures.

Figure 2 – Sample Anthem HIP Member Card with Dental and Vision

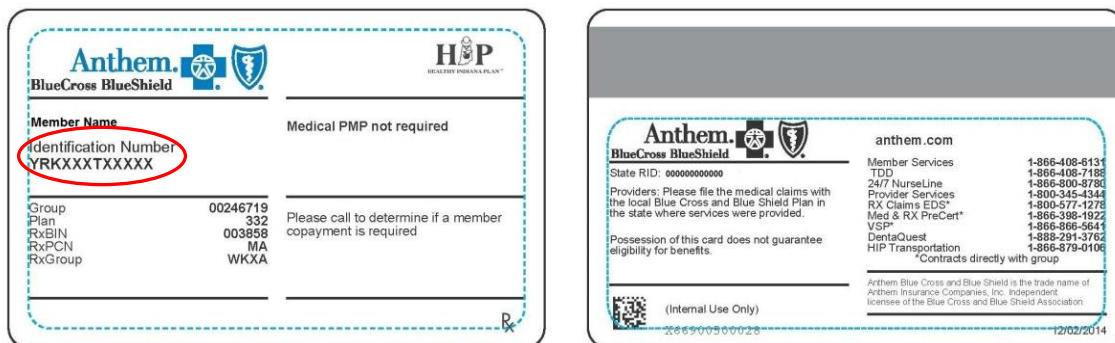


Figure 3 – Sample Anthem HIP Member Card without Dental and Vision

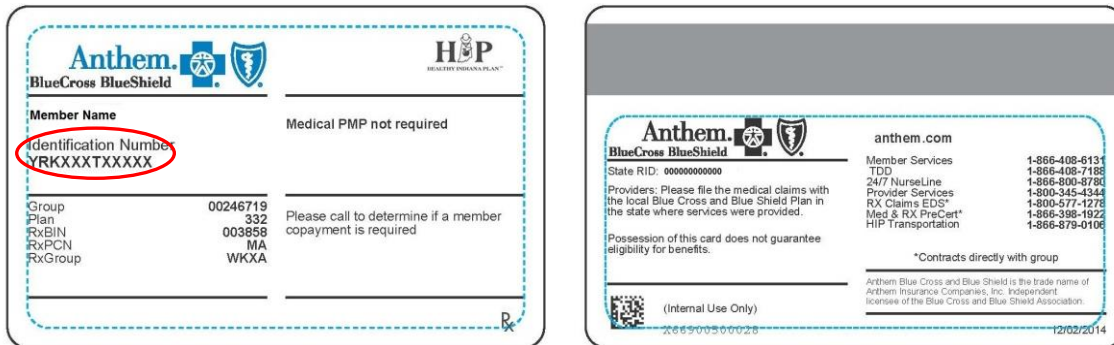


Figure 4 – Sample MHS HIP Member Card

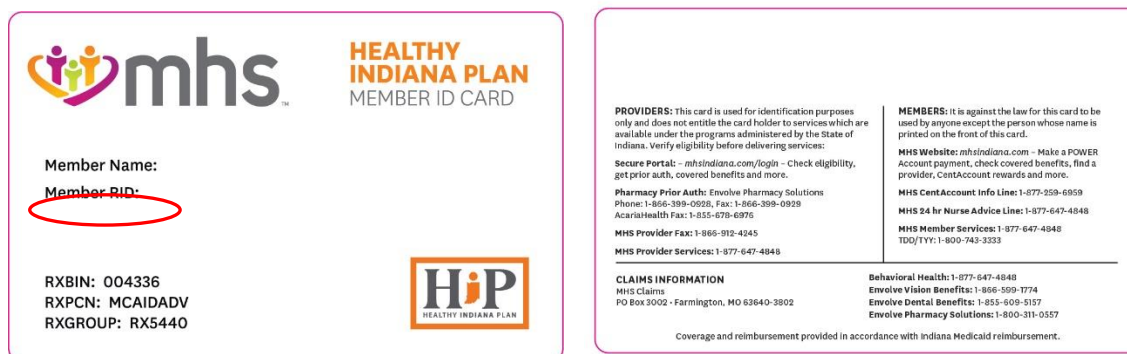


Figure 5 – Sample MDwise HIP Member Card



Figure 6 – Sample CareSource HIP Member Card





## Hoosier Care Connect Member Card

Hoosier Care Connect members receive member ID cards from their individual MCEs: Anthem or MHS. Examples of Hoosier Healthwise member cards are provided in Figures 7 and 8. Member identification numbers are located in the indicated areas.

Figure 7 – Sample Anthem Hoosier Care Connect Member Card





			
<b>MEMBER ID</b> (circled in red)		Primary Medical Provider:	
Group Plan RXBIN RxPCN RxGroup	631 003858 MA WKXA	Providers: Call MCE to confirm copays* Prescriptions <b>\$3.00</b> Transportation <b>\$1.00</b> Non-emergent ER <b>\$3.00</b> *Exempt: Under age 18, pregnant members.	Customer Care Center: 1-844-284-1797 TTY: 711 24/7 Nurse Line: 1-866-800-8780 Provider Helpline: 1-844-284-1798 Med. & RX Precept: 1-866-408-7187 Pharmacy Help Desk: 1-844-520-2680 Vision Service Plan*: 1-877-478-7561 DentaQuest*: 1-888-291-3762 LCP Transportation*: 1-800-508-7230 *Contracts directly with group Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies Inc., an independent licensee of the Blue Cross and Blue Shield Association.
		00/00/0000	

Figure 8 – Sample MHS Hoosier Care Connect Member Card

			
<b>MEMBER NAME:</b> XXXX XXX Long Name Here <b>MEMBER ID/RID: XXXXXXXXXX</b> (circled in red) Rx BIN: U08019		<b>MEMBER CO-PAYS:</b> Transportation: \$1 one way/\$2 round trip Prescriptions: \$3 per prescription Non-emergent Emergency Room: \$3	
<b>Copay Exceptions Include:</b> Members who are pregnant, Native American, less than 18 yrs old, or have met their 5% max. Other exceptions include medications for family planning and transportation to educational events or MAC meetings.		<b>PROVIDERS:</b> This card is used for identification purposes only and does not entitle the card holder to services which are available under the programs administered by the State of Indiana. Verify eligibility before delivering services. <b>Check Eligibility:</b> Phone: 1-877-647-4848 <b>Prior Auth:</b> Phone: 1-877-647-4848 <b>Fax:</b> 1-866-912-4245 <b>Pharmacy Prior Auth:</b> USS Phone: 1-866-399-0928 USS Fax: 1-866-399-0929, Acacia Fax: 1-855-678-6976 <b>Online:</b> Through the MHS Secure Provider Portal at <a href="http://mhsindiana.com/login">mhsindiana.com/login</a>	
		<b>MEMBERS:</b> It is against the law for this card to be used by anyone except the person whose name is printed on the front of this card. <b>MHS Member Services:</b> 1-877-647-4848 <b>CentAccount Info Line:</b> 1-877-259-6969 <b>MHS Member Website:</b> <a href="http://mhsindiana.com">mhsindiana.com</a> <b>MHS 24hr Nurse Advice Line:</b> 1-877-647-4848	
<b>CLAIMS INFORMATION</b> MHS Claims PO Box 3002 • Farmington, MO 63640-3802		<b>Centipatio/Behavioral Health Phone:</b> 1-877-647-4848 <b>Opticare Phone:</b> 1-866-599-1774 <b>DentaQuest Dental Phone:</b> 1-855-453-5286 <b>US Script Pharmacy Phone:</b> 1-855-772-7121	
Coverage and reimbursement provided in accordance with Indiana Medicaid reimbursement.			

## Hoosier Healthwise Member Card

Hoosier Healthwise members receive member ID cards from their individual MCEs: Anthem, CareSource, MHS, and MDwise.

*Note: Hoosier Healthwise updated its brand logo in April 2020. Samples from each MCE should be included in the next version of this module. Figure 9 provides an example of what the new cards might look like, although there will be variations depending on the MCE.*

Figure 9 – Sample Hoosier Healthwise Member Card



## Eligibility Verification System

Providers are required to verify member eligibility on the date of service. Providers that fail to verify eligibility are at risk of claims being denied due to member ineligibility or coverage limitations. Viewing a member ID card alone does not ensure member eligibility.

If the member is not eligible on the date of service, the member can be billed for services. However, it is important to remember that, if retroactive eligibility is later established, the provider must bill the IHCP and refund any payment that the member made to the provider.

Providers can verify member eligibility by using one of the following Eligibility Verification System (EVS) options:

- Provider Healthcare Portal (Portal) – See the [Eligibility Verification on the Portal](#) section for instructions.
- Approved vendor software for the 270/271 batch or interactive eligibility benefit transactions – See the [Electronic Data Interchange](#) module for details.
- Interactive Voice Response (IVR) system at 1-800-457-4584 – See the [Interactive Voice Response System](#) module for instructions. (Customer Assistance representatives do not provide eligibility verification information.)

Providers can use information from a member's health card to access eligibility information on the EVS. If a member does not have a member ID card at the time of service, a provider can still verify eligibility if the provider has one of the following:

- The member's IHCP Member ID
- The member's Social Security number and date of birth
- The member's first and last name and date of birth

## Information Available through the EVS

It is important that providers verify member eligibility on the date of service. If a provider fails to verify eligibility on the date of service, the provider risks claim denial. Claim denial could result if the member was not eligible on the date of service, or if the service provided was outside the member's scope of coverage. Most claim denials are due to missing or incorrect information that should have been verified through one of the EVS options.

Before rendering services, providers should always check member eligibility to determine the following:

- Whether the individual has IHCP coverage on the date of service
- What type of IHCP coverage the member has on the date of service (see [Table 1](#) for a list of benefit plans associated with the various IHCP programs)
- Whether the member has other insurance coverage (known as third-party liability [TPL]) that takes precedence over the IHCP coverage
- Whether the member has a copayment responsibility for certain services
- Whether a member is enrolled through a managed care program (such as HIP, Hoosier Care Connect, or Hoosier Healthwise) and, if so, to which MCE and PMP the member is assigned (name and telephone number) and the MCE delivery network associated with the member's PMP, if applicable

*Note: If the EVS indicates that the member is enrolled in a managed care program, the MCE identified must be contacted for more specific program information.*

*If the EVS indicates that the member has a PMP, the physician identified must be contacted to determine whether a referral is needed. If the member has been assigned to multiple PMPs during the time period of the eligibility request, the eligibility response includes each PMP and the PMP-MCE information with the date segments that the member was assigned to the PMP.*

- Whether the member is restricted to a designated pharmacy, hospital, and physician (PMP) through the Right Choices Program
- What level of care (LOC) is assigned for long-term care (LTC) or hospice members as well as whether a member who resides in an LTC facility has a patient liability and, if so, how much liability to collect from the member
- Whether the member has a waiver liability
- What services are authorized under the member's Medicaid Rehabilitation Option (MRO) or 1915(i) State Plan Home and Community-Based Services (HCBS) benefit (for applicable provider types only)
- Whether member benefit limitations have been reached

*Note: Benefit limit information provided by the EVS reflects only claims that are processed in CoreMMIS. Claims paid by MCEs are not reflected in the EVS benefit limit information.*



## ***EVS Update Schedule***

The DFR authorizes and initiates actions that affect member eligibility. The EVS is updated daily with member eligibility information transmitted from the ICES. The timing of the process (with the exception of Friday's activity) is as follows:

1. Information from ICES is downloaded from all counties daily after the close of business.
2. This file is passed electronically to *CoreMMIS* between midnight and 5 a.m. the next day.
3. *CoreMMIS* completes file processing by 9 a.m. the same day it receives the file.
4. The EVS is updated around 11 p.m. the day the file was processed. In the case of Friday's activity, the EVS is not updated until 11 p.m. Sunday.

The entire process takes 2 days to complete, with the exception of Friday's activity, which takes 3 days to complete. For example, if a DFR worker makes changes on Monday and the changes are transmitted to *CoreMMIS* Tuesday morning, between midnight and 5 a.m., *CoreMMIS* completes processing of Monday's file by 9 a.m. Tuesday. The EVS is updated by 11 p.m. Tuesday.

## ***Verifying Eligibility for a Specific Date of Service***

All eligibility verification options can be used to verify the eligibility status of a member for dates of service up to 7 years in the past. Eligibility inquiries are limited to a 1-calendar-month date span.

*Note: Eligibility cannot be verified for future dates, because eligibility cannot be guaranteed before the date of service.*

Providers may verify eligibility for members for any date of service that is within the provider's IHCP enrollment period. However, the EVS restricts providers from accessing member eligibility information for dates of service on which the provider was not actively enrolled in the IHCP. If providers enter a date span, each day in the date span must be within the provider's enrollment period. For example, if the provider is enrolled in the IHCP from 11/1/15 to 5/7/19, and an eligibility inquiry is entered for a date span of 5/1/19 to 5/10/19, the dates of 5/8, 5/9, and 5/10 all fall outside the provider's enrollment period. Even though there are some days that fall within the date range, because there are some days that fall outside, the inquiry on eligibility verification will not be allowed.

## ***Proof of Eligibility Verification***

Providers must retain proof that member eligibility was verified. For verification conducted via the IVR system, providers must document the verification number provided by the IVR system and record it for future reference. In the event that a discrepancy exists between the verification information obtained on the date of service and eligibility information on file, the verification number can be used to resolve the matter for claim processing.

The Portal contains a time-and-date stamp used for proof of timely eligibility verification. If a provider is required to prove timely eligibility verification, the provider must send a screen print from the Portal to the Written Correspondence Unit with a completed claim. The [Claim Submission and Processing](#) module provides additional information about written correspondence policies.

## Eligibility Verification on the Portal

To verify eligibility online via the Portal, users must first establish a registered account on the Portal, as described in the [Provider Healthcare Portal](#) module.

Use the following steps to verify eligibility on the Portal:

1. Log in to the Provider Healthcare Portal, accessible from the home page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).
2. Click the Eligibility tab on the Portal menu bar to access the Eligibility Verification Request panel.
3. Enter one of the following:
  - Member ID
  - Member’s Social Security number (SSN) and birth date
  - Member’s last name, first name, and birth date
4. Enter the date, or date range, for which eligibility is being checked:
  - The **Effective From** field is always required. If a date is not entered in this field, the Portal defaults this field to the current date. This field only accepts current and previous dates.
  - The **Effective To** field is optional. If a date is entered, it must be on or after the date in the Effective From field and must be within the same calendar month as that date. If a date is not entered in this field, it will default to the date in the Effective From field.
5. Click **Submit** to determine the member eligibility for the specified date or date range.

Figure 10 – Eligibility Verification Request Panel

**Eligibility Verification Request**

\* Indicates a required field.  
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID: 000000000000      Last Name:      First Name:      Birth Date:      SSN:      Effective From: 02/13/2017      Effective To: 02/13/2017

**Submit**      **Reset**

6. The Portal displays results of the search:
  - If the search criteria do not match information in the Portal, a message appears above the search panel stating: “Error: Member not found; confirm and/or revise search criteria.” (See [Figure 11](#).)
  - If the Portal finds results for the search criteria entered, but the member does not have coverage for the dates searched, the words “Not Eligible” appear in the coverage details for that member. (See [Figure 12](#).)
  - If the Portal finds coverage for the dates entered, it lists the member’s benefit plans, as well as additional information, in the *Coverage Details* panel. (See [Figure 13](#).)

Figure 11 – Eligibility Verification Request – No Information Found

**Error**  
Member not found, confirm and/or revise search criteria.

**Eligibility Verification Request**

\* Indicates a required field.  
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID: 100100100100      Last Name:      First Name:      Birth Date:      SSN:      Effective From: 06/13/2019      Effective To: 06/13/2019

**Submit**      **Reset**

Figure 12 – Eligibility Verification Request – No Coverage for Dates Searched

Coverage Details for Jane X XXSmith from 11/02/2017 to 11/02/2017

Member ID 100100100100

Birth Date 01/01/1950

[Expand All](#) | [Collapse All](#)

Verification Response ID 1001001001

Benefit Details

Coverage	Description	Effective Date	End Date
Not Eligible		11/02/2017	11/02/2017

Demographic Details

Figure 13 – Eligibility Verification Information

Coverage Details for				from 02/14/2020 to 02/14/2020	
Member ID		Birth Date		<a href="#">Expand All</a>   <a href="#">Collapse All</a>	
Verification Response ID					
Benefit Details					
Coverage		Description		Effective Date	End Date
Full Medicaid		Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)		02/14/2020	02/14/2020
Coverage		Description and Copayment Message			Copay Amount
Full Medicaid		Medical Care - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Chiropractic - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Dental Care - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Hospital - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Emergency Services - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Professional (Physician) Visit - Office - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Hospital - Inpatient - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Urgent Care - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Mental Health - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Vision (Optometry) - Copay is not applicable to this type of service.			\$0.00
Full Medicaid		Medically Related Transportation - The copay amount for transportation services will range from \$0.50 to \$2.00 based on the allowed amount for the procedure code. Please see the IHCP provider reference modules for more details.			\$2.00
Full Medicaid		Hospital - Outpatient - Copay applies only to non-emergency services.			\$3.00
Full Medicaid		Pharmacy - The copay for Pharmacy services is \$3.00 for legend and non legend drugs and insulin for each covered drug dispense. Please refer to the Pharmacy Reference module for additional information on copay exemptions.			\$3.00
Limit Details					
Managed Care Assignment Details					
Other Insurance Details					

*Note: For a claim to be considered for payment, the date of service must fall within an effective date range.*

7. Within the *Coverage Details* panel, all panels other than *Benefit Details* are initially collapsed. As you expand (+) the panels, you are able view to more information. You can also select *Expand All* to display all the information for all the panels. Only panels applicable to the member's coverage are displayed.

The following sections describe all possible panels returned with an eligibility verification request.

## Benefit Details

The *Benefit Details* panel lists the member's coverage, including benefit plan name and description, and copayment amounts:

- For more information about IHCP benefit plans, see [Table 1](#) and the [Fee-for-Service Programs and Benefits](#), [Managed Care Programs](#), and [Special Programs and Processes](#) sections.
- For more information about copayments, see the [Member Copayment Policies](#) section.

Figure 14 – Benefit Details

Benefit Details			
Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	02/14/2020	02/14/2020
Coverage	Description and Copayment Message	Coplay Amount	
Full Medicaid	Medical Care - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Dental Care - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Hospital - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Emergency Services - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Professional (Physician) Visit - Office - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Hospital - Inpatient - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Urgent Care - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Mental Health - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Vision (Optometry) - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Medically Related Transportation - The copay amount for transportation services will range from \$0.50 to \$2.00 based on the allowed amount for the procedure code. Please see the IHCP provider reference modules for more details.	\$2.00	
Full Medicaid	Hospital - Outpatient - Copay applies only to non-emergency services.	\$3.00	
Full Medicaid	Pharmacy - The copay for Pharmacy services is \$3.00 for legend and non legend drugs and insulin for each covered drug dispense. Please refer to the Pharmacy Reference module for additional information on copay exemptions.	\$3.00	

## Limit Details

The *Limit Details* panel lists certain service or dollar limits that may be applicable for a member. The panel shows a description of the limit, the limit amount allowed, and the amount that is still remaining to the member. The amount indicated as remaining is based on FFS paid claims. The *actual* amount remaining may be different – for example, if a service has been rendered but the claim has not yet been paid. See [Section 6: Benefit Limit Information](#) for more information.

Figure 15 – Limit Details

Limit Details		
The Dollar Limits and Service Limits may not reflect recent claims.		
Dollar Limits	Limit	Remaining
6113 DME LIMITED TO \$2000 PER MEMBER PER CAL YR	\$2,000.00	-
Service Limits	Limit	Remaining
6830 TRANSPORT: ONE-WAY TRIP IN EXCESS OF 20/12 MONTHS	20	14

## Managed Care Assignment Details

For members enrolled in a managed care program, such as HIP, Hoosier Care Connect, or Hoosier Healthwise, the *Managed Care Assignment Details* identifies the member's managed care program, PMP name and telephone number, MCE name and telephone number, and delivery network associated with the PMP, if a delivery network is applicable. The option to submit a Notification of Pregnancy (NOP) for managed care members is also available from this panel; see the [Obstetrical and Gynecological Services](#) module for details.

Figure 16 – Managed Care Assignment Details – Managed Care

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Hoosier Care Connect		XXXXXXXXXXXXXX	XXXXXXXXXXXXXX
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
06/21/2018	06/21/2018	ANTHEM	XXXXXXXXXXXXXX
<input type="button" value="Enter NOP"/> <input type="button" value="Print Blank NOP"/>			

For FFS members subject to brokerage requirements for nonemergency medical transportation (NEMT) services, the *Managed Care Assignment Details* panel displays the name of the broker that must be used to arrange the transportation. These members are still considered FFS for all other services; however, scheduling and billing of the NEMT service must be done through the broker, as described in the [Transportation Services](#) module.

Figure 17 – Managed Care Assignment Details – FFS with Brokered NEMT

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
06/21/2018	06/21/2018	SOUTHEASTTRANS, INC	

## Right Choices Program

The *Right Choices Program* panel lists the providers assigned to the Right Choices Program (RCP) member. These providers are approved for a member to use for services. See the [Right Choices Program](#) module for details.

Figure 18 – Right Choices Program

Right Choices Program				
RCP Provider	RCP Provider Phone	Service	Effective Date	End Date
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	RCP-Physician	11/21/2016	11/21/2016
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	RCP-Pharmacy	11/21/2016	11/21/2016
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	RCP-Inpatient Hospital	11/21/2016	11/21/2016
XXXXXXXXXXXXXX	XXXXXXXXXXXXXX	RCP-Outpatient Hospital	11/21/2016	11/21/2016

*Note: Effective April 30, 2020, the IHCP is removing the hospital lock-in requirement from the Right Choices Program. A primary lock-in hospital will no longer be required for RCP members.*



## Waiver Liability Details

The *Waiver Liability Details* panel shows the member's Medicaid waiver liability obligation and the remaining balance. The balance amount shown may not reflect claims not yet processed. Providers may bill the member for the amount credited to liability after the claim is adjudicated. See the [HCBS and ESRD Waiver Liability](#) section for details.

Figure 19 – Waiver Liability Details

Waiver Liability Details		
These amounts are based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied to Waiver Liability.		
Month	Waiver Liability Obligation	Waiver Liability Balance
March, 2014	\$100.00	\$76.37

## Nursing Home/Hospice Level of Care

The *Nursing Home/Hospice Level of Care* panel displays level of care (LOC), eligibility dates, and the member's liability obligation for the effective coverage. See the [Hospice Services](#) and [Long-Term Care](#) modules for more information.

Figure 20 – Nursing Home/Hospice Level of Care

Nursing Home / Hospice Level of Care		
Level of Care	Effective Date	End Date
Hospice Program	11/19/2013	12/31/2014
MR/DD Specialized Skilled Care in NF	12/01/2013	05/31/2014
Patient Liability/Client Obligation: \$1,200.00		

*Note: The Portal displays LOC information for FFS services only. To confirm hospice benefits provided under a managed care program, providers must contact the member's MCE.*

## Detail Information

The *Detail Information* panel displays information for authorized Medicaid Rehabilitation Option (MRO) and 1915(i) services. Note that only those users with the correct specialty for MRO or the 1915(i) specialties can see this information. All other provider specialties cannot see this data.

For details about these programs, see the [Medicaid Rehabilitation Option Services](#) and [1915\(i\) State Plan HCBS Program Services](#) sections.

Figure 21 – Detail Information

Detail Information									
									Total Records: 1
PA Number	Status	Provider	Code	Description	Service Dates	Units Authorized	Units Used	Amount Authorized	Amount Used
A111111111	APPROVED	PROVIDER NAME	H2012 HW HA U1	BEHAV HLTH DAY TREAT, PER HR	06/21/2017 – 12/18/2017	252	-	-	-

## Other Insurance Details

The *Other Insurance Details* panel displays information about other coverage, in addition to IHCP benefits, on file for the member. The information provided includes the carrier's name (and Carrier ID), address, and telephone number and the policyholder's policy ID, group ID, name, and coverage type. For more information about billing and reimbursement for members with other insurance, in addition IHCP coverage, see the [Third Party Liability](#) module.

Figure 22 – Other Insurance Details

Other Insurance Details						
Carrier Name (Carrier ID)	Address	Phone Number	Policy ID	Group ID	Policy Holder	Coverage Type
Medicare					JANE X XXSMITH (100100100X0)	MEDICARE A
Medicare					JANE X XXSMITH (100100100X0)	MEDICARE B
Medicare					JANE X XXSMITH (100100100X0)	MEDICARE PART D
CARRIER NAME PART D (0000000)	P.O. BOX 00000 XXCITY, IN 00000	1-800-000-0000	000	X0000	JANE X XXSMITH (100100100X0)	MEDICARE PART D

*Note: Providers can update information about a member's other insurance by using the Portal's Secure Correspondence link, with TPL Update selected as the category. See the [Provider Healthcare Portal](#) module for details.*

## Demographic Details

The *Demographic Details* panel displays the address on file for the member.

Figure 23 – Demographic Details

Demographic Details		
Street Address		
City	State Indiana	ZIP Code





## Section 2: Fee-for-Service Programs and Benefits

Indiana Health Coverage Programs (IHCP) members enrolled in programs delivered as fee-for-service (FFS) are not enrolled with a managed care entity (MCE) and are not required to choose a primary medical provider, unless they are assigned to the Right Choices Program. See the [Introduction to the IHCP](#) module for detailed information about the FFS delivery system.

The programs associated with the FFS delivery system include:

- Traditional Medicaid (identified in the IHCP Eligibility Verification System [EVS] as *Full Medicaid* or *Package A – Standard Plan* coverage with no managed care details)
- Medicare Savings Programs
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low Income Medicare Beneficiary (SLMB)
  - Qualified Individual (QI)
  - Qualified Disabled Working Individual (QDWI)

*Note: Members identified in the EVS as having both Qualified Medicare Beneficiary coverage and also Full Medicaid or Package A coverage are known as **QMB-Also**. Members identified as having both Specified Low Income Medicare Beneficiary coverage and also Full Medicaid or Package A coverage are known as **SLMB-Also**. Members who have only QMB coverage or only SLMB coverage (not in conjunction with Full Medicaid or Package A) are known as **QMB-Only** or **SLMB-Only**. See the [Medicare Savings Programs – QMB, SLMB, QI, QDWI](#) section for details.*

- Emergency Services Only (Package E)
- Family Planning Eligibility Program
- 590 Program
- Inpatient Hospital Services Only (for inmates)

*Note: Effective November 30, 2019, the IHCP expanded the Emergency Services Only (ESO) benefits for certain qualified immigrants identified as lawful permanent residents. This new FFS benefit plan is called **ESO Coverage with Pregnancy Coverage**, and may also be referred to as “Package B.” Package B covers prenatal and postpartum services until 60 days after the pregnancy ends, in addition to all services covered under **Package E – Emergency Services Only**.*

See the [Fee-for-Service Benefit Options](#) section for information about additional service options that are available on an FFS basis.

## Traditional Medicaid

The Traditional Medicaid program provides coverage for healthcare services rendered to individuals in the following groups who meet eligibility criteria, such as specific income guidelines:

- Persons in long-term care (LTC) facilities and other institutions, such as a nursing facility (NF) or an intermediate care facility for individuals with intellectual disability (ICF/IID)
- Persons eligible for Hoosier Healthwise who qualify for IHCP hospice benefits
- Persons eligible for a Home and Community-Based Services (HCBS) waiver program, including those with a waiver liability
- Persons with end-stage renal disease (ESRD), including those with a waiver liability
- Persons with both Medicare and Medicaid (dual eligibility)
- Persons enrolled in the Breast or Cervical Cancer Treatment Program
- Refugees who do not qualify for any other aid category
- Children receiving adoption assistance
- Wards of the State who opt out of Hoosier Care Connect
- Foster children
- Former foster children who turned 18 years of age while in foster care, are under age 26 (or under age 21, if the foster care was outside of Indiana), and opt out of Hoosier Care Connect

Traditional Medicaid members are eligible for full coverage of Medicaid services, as described in the *Indiana State Plan*. For details, see the *Indiana State Plan*, accessible from the [Provider Reference Materials](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

In conjunction with Full Medicaid/Package A – Standard Plan benefits, Traditional Medicaid members may, under certain circumstances, also be eligible for additional services, including 1915(c) HCBS waiver services, 1915(i) State Plan HCBS program services, Medicaid Rehabilitation Option (MRO) services, hospice services, and long-term care (LTC) services. These additional services are also delivered on an FFS basis. Providers must consult the EVS to determine the member's eligibility status and coverage details.

### ***Indiana Breast and Cervical Cancer Program***

Women diagnosed with breast or cervical cancer through the Indiana Breast and Cervical Cancer Program (BCCP) of the Indiana State Department of Health (ISDH) are eligible for Traditional Medicaid coverage during the course of treatment. These members are in the FFS delivery system only. To be eligible, a woman must meet the following criteria:

- Must be younger than 65 years old
- Must not be eligible for another Medicaid category
- Must not be covered by any other insurance that includes breast or cervical cancer treatment

Alternatively, a woman can receive coverage for treatment under the BCCP program if she was diagnosed with breast or cervical cancer, but not screened through BCCP, if:

- She is between the ages of 18 and 65.
- She has income at or below 200% of the federal poverty level (FPL).
- She is not eligible for Medicaid under any other category.
- She has no health insurance that will cover her treatment.

## HCBS and ESRD Waiver Liability

Some individuals with income in excess of the Traditional Medicaid threshold, who are approved for HCBS waiver services, are enrolled in Traditional Medicaid under the HCBS waiver liability provision. Waiver liability is similar to a deductible. Medicaid provider responsibilities to members enrolled under the waiver liability provision are published in *Indiana Administrative Code 405 IAC 1-1-3.1*. See the [1915\(c\) HCBS Waiver Services](#) section for information about special service options associated with HCBS waivers.

A similar waiver liability provision is available for some individuals approved for ESRD services. After ending the spend-down program, the IHCP instituted a temporary program that grants Traditional Medicaid eligibility to individuals with ESRD who were at risk of losing access to transplant services. To be eligible for the Medicaid ESRD waiver liability provisions, an individual must:

- Be eligible for Medicare
- Not be in an institutional setting or on a waiver
- Have income between 150% and 300% of the federal poverty level (FPL)

These individuals are subject to a monthly ESRD waiver liability. As authorized and approved by the Centers for Medicare & Medicaid Services (CMS) for the temporary program, the liability amount is calculated based on the previously used spend-down methodology.

Members with waiver liability must incur medical expenses in the amount of their excess income each month before becoming eligible for Traditional Medicaid. It is the member's responsibility to provide nonclaim verification of incurred medical expenses to the Division of Family Resources (DFR). The member becomes eligible at the beginning of the month, but payments are subject to reduction based on the amount of waiver liability remaining for the month.

A provider may bill a member for the amount listed under PATIENT RESP on the Remittance Advice (RA). With the exception of point-of-sale (POS) pharmacy claims, the IHCP does not require the member to pay the provider until the member receives the liability summary notice. The IHCP notifies pharmacists of the amount the member owes at the time the POS claim adjudicates so that the pharmacists can collect from the members at the time of service. The IHCP permits the provider to bill a member after the second business day of the month following the month the claim was adjudicated. The provider may not apply a more restrictive collection policy to members with liability than to other patients or customers. If the provider has a general policy to refuse service to a patient or customer with an unpaid bill, that policy may not be applied to a member with liability before the member receives the liability summary notice. Providers must bill their usual and customary charge to Medicaid. The maximum amount a provider can bill a member is the lesser of the liability obligation remaining at the time the claim adjudicates or the usual and customary charge. For more information on waiver billing information, see the [Home and Community-Based Services Billing Guidelines](#) module.

When a provider verifies member eligibility, if the member has a liability (either for HCBS waiver or ESRD waiver), the EVS indicates the dollar amount of the remaining liability obligation for the month. On the Provider Healthcare Portal (Portal), this liability amount is listed in the *Waiver Liability Details* panel; see Figure 24. Providers can use the enhanced liability information to assist members with financial planning for payment of the liability. Providers may not collect the liability obligation from the member at the time of service. A provider may bill the member for the amount credited to liability after the provider receives an RA showing that the claim has been adjudicated.

Figure 24 – Waiver Liability Details Panel in the Portal Eligibility Verification

Waiver Liability Details		
These amounts are based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the Waiver Liability amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Waiver Liability Summary Notice listing the amount applied to Waiver Liability.		
Month	Waiver Liability Obligation	Waiver Liability Balance
March, 2017	\$100.00	\$76.37

## Benefit Limits and Waiver Liability

In general, denied services do not credit waiver liability. For example, a service that is not covered by Medicaid under *Indiana Administrative Code 405 IAC 5*, and therefore denied by the IHCP, does not credit waiver liability. However, a service that is denied because the member exceeds a benefit limit that cannot be overridden with an approved prior authorization may credit waiver liability. See the [Benefit Limit Information](#) section for more information about benefit limits.

## Medicare Part D and Medicaid Waiver Liability

When a member qualifies for the Medicare Low-Income Subsidy (LIS), Medicare considers the member qualified for the remainder of the calendar year. If the member qualifies for the Medicare LIS after the first half of the current calendar year, Medicare considers the member qualified until the end of the next calendar year. When qualified, Medicare Part D members are able to receive prescription drug coverage from Medicare every month without waiting to meet the monthly Medicaid waiver liability.

Members must meet their monthly Medicaid waiver liability requirements prior to receiving Medicaid benefits. Although members may not meet Medicaid waiver liability requirements as quickly, other medical expenses, Medicare copayments, and Medicare-excluded drugs covered by the IHCP still count toward the Medicaid waiver liability. Until Medicaid waiver liability is met, members are responsible for the provider's usual and customary charges (UCCs) for IHCP-covered drugs and other IHCP-covered health services. Providers are not required to dispense IHCP-covered drugs if the member's waiver liability has not been met.

## Medicare Savings Programs – QMB, SLMB, QI, QDWI

Federal law requires that state Medicaid programs pay Medicare coinsurance or copayment, deductibles, and/or premiums for certain elderly and disabled individuals through a program called the Medicare Savings Program. These individuals must meet the following eligibility criteria to receive assistance with Medicare-related costs:

- Entitled to Medicare
- Low income
- Few personal resources

*Note: The terms coinsurance and copayment are interchangeable. When referred to in outputs such as the IVR, Portal, Remittance Advice, and so forth, the term “coinsurance” represents coinsurance and/or copayment.*

Medicare Savings Program coverage falls into the following categories shown in Table 2.

For all QMBs, the IHCP pays the Medicare Part B premiums and Medicare Part A (as necessary), as well as Medicare deductibles and coinsurance or copayment for Medicare-covered services when the Medicare payment amount is less than the Medicaid allowed reimbursement amount. The member is never responsible for the amount disallowed (paid at zero) when Medicare paid more than the Medicaid allowed amount for the service.

Table 2 – Medicare Savings Program Coverage Categories

Coverage Type	Description of Coverage	Notes
QMB-Only	<p>The member's benefits are limited to payment of:</p> <ul style="list-style-type: none"> <li>The member's Medicare Part A (if not entitled to free Part A) and Part B premiums</li> <li>Deductibles and coinsurance or copayment for Medicare-covered services</li> </ul> <p><b>IHCP claims for services not covered by Medicare are denied as Medicaid noncovered services.</b> The member must make payment in full for medical supplies, equipment, and other services not offered by Medicare, such as routine physicals, dental care, hearing aids, and eyeglasses.</p>	<p>When the EVS identifies a member as having only <i>Qualified Medicare Beneficiary</i> coverage (without also having <i>Full Medicaid</i> or <i>Package A – Standard Plan</i> coverage), <b>the provider should contact Medicare to confirm medical coverage.</b> Failure to confirm coverage may result in a claim denial because Medicare benefits may have been discontinued or recently denied.</p> <p>Providers should tell the member that the service is not a Medicaid-covered service for a member who has only QMB coverage. If the member still wants the service, the member is responsible for payment. See the <a href="#">Provider Enrollment</a> module for additional information about billing an IHCP member for noncovered services.</p>
QMB-Also without waiver liability	<p>The member's benefits include payment of:</p> <ul style="list-style-type: none"> <li>The member's Medicare Part A (if not entitled to free Part A) and Part B premiums</li> <li>Deductibles and coinsurance or copayment on Medicare-covered services</li> <li>Traditional Medicaid benefits (excluding prescription drug coverage, as stated in the <a href="#">Medicaid and the Medicare Prescription Drug Coverage Program</a> section) throughout each month of eligibility</li> </ul>	<p>When the EVS identifies a member as having <i>Qualified Medicare Beneficiary</i> coverage and also <i>Full Medicaid</i> or <i>Package A – Standard Plan</i> coverage, claims for services covered by Medicare may cross over to Medicaid for additional payment consideration.</p> <p><b>Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.</b></p>
QMB-Also with waiver liability	<p>The member's benefits include payment of:</p> <ul style="list-style-type: none"> <li>The member's Medicare Part A (if not entitled to free Part A) and Part B premiums</li> <li>Deductibles and coinsurance or copayment for Medicare-covered services</li> <li>Traditional Medicaid benefits (excluding prescription drug coverage, as stated in the <a href="#">Medicaid and the Medicare Prescription Drug Coverage Program</a> section) <b>after the member's monthly liability is met</b></li> </ul>	<p>When the EVS identifies a member as having <i>Qualified Medicare Beneficiary</i> coverage and also <i>Full Medicaid</i> or <i>Package A – Standard Plan</i> coverage, but with an unmet waiver liability, claims may process toward the member's waiver liability amount; however, until the waiver liability is satisfied for the month, the member's benefits are limited to payment of Medicare premium and deductibles, coinsurance, or copayment for Medicare-covered services.</p>

Coverage Type	Description of Coverage	Notes
SLMB-Only	<p>The member's benefits are limited to payment of the member's Medicare Part B premium only.</p> <p>Providers should tell the member that the service is not a Medicaid-covered service for a member who has only SLMB coverage.</p>	<p>When the EVS identifies a member as having only <i>Specified Low Income Medicare Beneficiary</i> coverage (without also having <i>Full Medicaid</i> or <i>Package A – Standard Plan</i> coverage), <b>the provider should contact Medicare to confirm medical coverage.</b> Failure to confirm coverage may result in a claim denial because Medicare benefits may have been discontinued or recently denied. If the member still wants the service, the member is responsible for payment. See the <a href="#">Provider Enrollment</a> module for additional information about billing an IHCP member for noncovered services.</p>
SLMB-Also without waiver liability	<p>The member's benefits include payment of:</p> <ul style="list-style-type: none"> <li>• The member's Medicare Part B premium</li> <li>• Traditional Medicaid benefits (excluding prescription drug coverage, as stated in the <a href="#">Medicaid and the Medicare Prescription Drug Coverage Program</a> section) throughout each month of eligibility</li> </ul>	<p>When the EVS identifies a member as having <i>Specified Low Income Medicare Beneficiary</i> coverage and also <i>Full Medicaid</i> or <i>Package A – Standard Plan</i> coverage, claims for services covered by Medicare may cross over to Medicaid for additional payment consideration. <b>Medicaid claims for services not covered by Medicare must be submitted as regular Medicaid claims and not as crossover claims.</b></p>
SLMB-Also with waiver liability	<p>The member's benefits include payment of:</p> <ul style="list-style-type: none"> <li>• The member's Medicare Part B premium</li> <li>• Traditional Medicaid benefits (excluding prescription drug coverage, as stated in the <a href="#">Medicaid and the Medicare Prescription Drug Coverage Program</a> section) <b>after the member's monthly liability is met</b></li> </ul>	<p>When the EVS identifies a member as having <i>Specified Low Income Medicare Beneficiary</i> coverage and also <i>Full Medicaid</i> or <i>Package A – Standard Plan</i> coverage, but with an unmet waiver liability, claims may process toward the member's waiver liability amount; however, until the waiver liability is satisfied for the month, the member's benefits are limited to payment of the Medicare Part B premium.</p>
QI	The member's benefit is limited to payment of the member's Medicare Part B premium only.	The EVS identifies this coverage as <i>Qualified Individual</i> .
QDWI	The member's benefit is limited to payment of the member's Medicare Part A premium only.	The EVS identifies this coverage as <i>Qualified Disabled Working Individual</i> .



## ***Eligibility Verification for QMB-Also and SLMB-Also Members with Liability***

The EVS options (Portal, IVR system, or 270/271 transaction) return the following eligibility information for QMB-Also and SLMB-Also members with a waiver liability:

- That the member is QMB-Also or SLMB-Also:
  - For QMB-Also members, the EVS indicates both *Qualified Medicare Beneficiary* coverage and also *Full Medicaid* or *Package A* coverage
  - For SLMB-Also members, the EVS indicates both *Specified Low Income Medicare Beneficiary* coverage and also *Full Medicaid* or *Package A* coverage
- That the member has liability
- Whether or not the member's liability has been met for the month
- If the member's liability has not been met, the amount that remains for the month

The EVS maintains all historical waiver liability information. The EVS reports the dollar amount of the remaining liability obligation for the month.

Services rendered up to the cost of the member liability are the responsibility of the member to pay to the rendering provider, and it is the responsibility of the provider to collect the liability payment from the member. Providers may not collect the liability obligation from the member until the claim is adjudicated showing that the member liability has been applied to the provider claim.

Costs for rendered services beyond the liability are paid by the IHCP, and medically necessary services beyond the cost of the liability must still be provided to the member.

## ***Medicaid and the Medicare Prescription Drug Coverage Program***

With implementation of the *Medicare Modernization Act* (MMA) and Medicare Part D prescription drug coverage program (Medicare Part D), the IHCP can no longer pay for Medicare-covered prescription drugs. Medicaid covers excluded Medicare Part D drugs that are listed on the IHCP Over-the-Counter Drug Formulary and barbiturates (when used for medically accepted indications *other than* epilepsy, cancer, or chronic mental health disorders; for example, the combination product butalbital/aspirin/cafeine, indicated for headaches). Enrollment in Medicare Part D prescription drug coverage is voluntary.

Medicaid members who receive full Medicaid benefits and who are enrolled in Medicare Part A or Part B do not have coverage for Medicare Part D-covered drugs unless they join, or are auto-enrolled by Medicare into, a Medicare prescription drug plan (PDP). Medicaid does not pay for Medicare Part D-covered drugs for people who are enrolled in Medicare or who decline the Medicare Part D coverage or disenroll from the Medicare PDP.

*Note: The IHCP does not cover compounded drug products containing a Medicare Part D-covered drug product for dually eligible members.*

The Medicare LIS, also known as “Extra Help,” is a federal subsidy provided by Medicare that helps members pay for their Medicare PDP premiums, copays, and deductibles. Members need to apply for this assistance program through Social Security at 1-800-722-1213 or access help online at the [Social Security website](https://www.ssa.gov/socialsecurity) at socialsecurity.gov. If the member chooses a Medicare PDP with higher premiums than the amount that Medicare will subsidize, he or she will have to pay the difference. Assistance can also be obtained through any of the local Social Security offices in the member's area.

Questions about Medicare prescription drug coverage can be directed to Medicare at 1-800-Medicare (1-800-633-4227), TTY users 1-877-486-2048, or the [Medicare website](https://www.medicare.gov) at medicare.gov. Members can contact Medicare or State Health Insurance Assistance Program (SHIP) at 1-800-452-4800

(1-866-846-0139 for TTY users) for help choosing a Medicare prescription drug plan or applying for the “Extra Help.”

## Emergency Services Only – Package E

Emergency Services Only (Package E) is for individuals who are otherwise eligible for Medicaid, but who may not meet citizenship or immigration-status requirements for the program. Health coverage under Package E is limited to treatment for medical emergency conditions. The *Omnibus Budget Reconciliation Act of 1986* (OBRA) defines an **emergency medical condition** as follows:

A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member’s health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part

In the case of pregnant women eligible for coverage under Package E, labor and delivery services are also considered emergency medical conditions.

*Note: Effective November 30, 2019, the IHCP provides ESO Coverage with Pregnancy Coverage (Package B) benefits for women who are lawful permanent residents. In addition to all services covered under Package E, Package B provides prenatal and postpartum services until 60 days after the pregnancy ends.*

Children born in the United States to Package E members are eligible for full IHCP coverage upon determination of eligibility through the DFR. (Outreach locations can screen for eligibility using established guidelines; however, the final eligibility determination is made through DFR.) Children who are not born in the United States are eligible only under Package E, unless the child is a current U.S. citizen, a qualified alien, or a lawful permanent resident who has resided in the United States for 5 years or longer. These children are only eligible for emergency coverage, and are not covered under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program.

Package E members are in the FFS delivery system only. For billing instructions for Package E claims, see the [Claim Submission and Processing](#) module.

## Family Planning Eligibility Program

The Family Planning Eligibility Program provides only family planning services to qualifying men and women, per *Indiana Code IC 12-15-46 Medicaid Waivers and State Plan Amendments*.

The Family Planning aid category includes men and women of any age who:

- Do not qualify for any other category of Medicaid
- Are not pregnant
- Have not had a hysterectomy or sterilization
- Have income that is at or below 141% of the federal poverty level
- Are U.S. citizens, certain lawful permanent residents, or certain qualified documented aliens

Services rendered to members in the Family Planning Eligibility Program are reimbursed through the FFS delivery system. Providers must verify eligibility before rendering services.



The Family Planning Eligibility Program provides services and supplies to men and women for the primary purpose of preventing or delaying pregnancy. Services covered under the Family Planning Eligibility Program include:

- Annual family planning visits, including health education and counseling necessary to understand and make informed choices about contraceptive methods
- Limited history and physical examinations
- Laboratory tests, if medically indicated as part of the decision-making process regarding contraceptive methods
- Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, within the parameters described in the [Obstetrical and Gynecological Services](#) module
- Follow-up care for complications associated with contraceptive methods issued by the family planning provider
- Food and Drug Administration (FDA)-approved oral contraceptives and contraceptive devices and supplies, including emergency contraceptives
- Initial diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs), if medically indicated, including the provision of FDA-approved anti-infective agents
- Screening, testing, counseling, and referral of members at risk for human immunodeficiency virus (HIV), within the parameters described in the [Laboratory Services](#) module
- Tubal ligations
- Hysteroscopic sterilization with an implant device
- Vasectomies

IHCP reimbursement is available for Family Planning Eligibility Program-covered services rendered by IHCP-enrolled providers, including but not limited to physicians, certified nurse midwives, family planning clinics, and hospitals. Family Planning Eligibility Program services may be self-referred.

Services **not covered** under the Family Planning Eligibility Program include:

- Abortions
- Any drug or device intended to terminate fertilization
- Artificial insemination
- In vitro fertilization (IVF)
- Fertility counseling
- Fertility treatment
- Fertility drugs
- Inpatient hospital stays
- Reversal of tubal ligation and vasectomies
- Treatment for any chronic condition, including STDs and STIs that have advanced to a chronic condition
- Emergency room services
- Services unrelated to family planning

For more information, see the [Family Planning Eligibility Program](#) module.

## 590 Program

The 590 Program provides coverage for certain healthcare services provided to members 21 through 64 years of age who are residents of state-owned facilities. These facilities operate under the direction of the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) and the Indiana State Department of Health (ISDH). Incarcerated individuals residing in Department of Correction (DOC) facilities are not covered by the 590 Program.

The 590 Program is part of the fee-for-service delivery system. Members enrolled in the 590 Program are eligible for the full array of benefits covered by the IHCP, with the exception of transportation services (which are provided by facility). Coverage is limited to services performed outside the 590 Program facility and to claims over \$150 dollars. Only 590-enrolled providers can render services to 590 Program members.

For more information about program eligibility, coverage, and reimbursement, see the [590 Program](#) module.

## Fee-for-Service Benefit Options

Members meeting certain eligibility criteria may be eligible for services in addition to their primary benefit plan. The following additional services are delivered and reimbursed through the FFS delivery system:

- 1915(c) Home and Community-Based Services (HCBS) waiver services – Certified individuals may receive home and community-based services under a Medicaid waiver, in conjunction with Traditional Medicaid benefits. (For some HCBS waiver services, Money Follows the Person [MFP] demonstration grant services are available as a precursor to HCBS waiver eligibility.)
- 1915(i) State Plan HCBS program services – Certified individuals may receive designated home and community-based nonwaiver services in conjunction with Traditional Medicaid, Hoosier Care Connect, or Hoosier Healthwise benefits. (Behavioral and Primary Healthcare Coordination [BPHC] services may also be delivered in conjunction with *HIP State Plan* and *HIP Maternity* benefits.)
- MRO services – Certified individuals may receive MRO services in conjunction with Traditional Medicaid, *HIP State Plan*, *HIP Maternity*, Hoosier Care Connect, or Hoosier Healthwise benefits.
- Hospice services – Members enrolled in the Hoosier Healthwise managed care program may be required to transition to Traditional Medicaid (under the FFS delivery system) to receive coverage of in-home and/or institutional hospice services. (For all other managed care programs, hospice services are covered within the managed care delivery system.) See the [Hospice Services](#) module for details.
- Long-term care – Members enrolled in a managed care program may be required to transition to Traditional Medicaid (under the FFS delivery system) to receive coverage of long-term care services. See the [Long-Term Care](#) module for details.

### 1915(c) HCBS Waiver Services

HCBS waivers cover a variety of home and community-based services not otherwise reimbursed by the IHCP. HCBS waivers are available to those IHCP-eligible members who require the level-of-care (LOC) services provided in a nursing facility, hospital, or ICF/IID, but choose to remain in the home.

Eligibility for all HCBS waivers requires the following:

- The member must meet IHCP eligibility guidelines for Traditional Medicaid.
- The member would require institutionalization in the absence of the waiver or other home-based services.
- If the member is enrolled in managed care, the member must be disenrolled from managed care and enrolled in Traditional Medicaid to receive authorized HCBS waiver services.

Members served under an HCBS waiver are ineligible for services under any other waiver. The HCBS waivers are not entitlement programs and can serve only a limited number of members.

Indiana offers four HCBS waivers that target specific groups:

- See the [Division of Aging Home and Community-Based Services Waivers](#) module for information about the following two waivers for individuals who meet nursing facility (NF) level of care:
  - Aged and Disabled Waiver
  - Traumatic Brain Injury Waiver
- See the [Division of Disability and Rehabilitative Services Home and Community-Based Services Waivers](#) module for information about the following two waivers for individuals who meet ICF/IID level of care:
  - Community Integration and Habilitation Waiver
  - Family Supports Waiver

HCBS waiver services allow members to live in a community setting and avoid institutional placement. To be eligible for any waiver program, an individual must meet both Medicaid guidelines and waiver eligibility guidelines.

*Note: The Division of Aging also administers the Money Follows the Person (MFP) program, which is funded through a federal grant from the CMS. Indiana's MFP program is specifically designed as a transition program to assist individuals who live in qualifying institutions to move safely into the community and to ensure a safe adjustment to community living. MFP serves eligible members for up to 365 days, until they transition into the 1915(c) HCBS waiver that the grant is mirrored after: Traumatic Brain Injury (TBI) or Aged and Disabled (A&D). All potential MFP demonstration grant recipients must be enrolled in the IHCP Traditional Medicaid program. For more information about the MFP program, see the [Money Follows the Person](#) page at [in.gov/fssa](http://in.gov/fssa).*

## **1915(i) State Plan HCBS Program Services**

Section 1915(i) of the *Social Security Act* (SSA) gives states the option to offer a wide range of home and community-based services to members through state Medicaid plans. Using this option, states can offer services and supports to a target group of individuals, including individuals with serious mental illness, emotional disturbance, and substance use disorders to help them remain in the community. Eligible individuals may receive authorized services in conjunction with Traditional Medicaid, *HIP State Plan*, Hoosier Care Connect, or Hoosier Healthwise benefits.

Indiana administers the following 1915(i) State Plan HCBS programs through the FSSA DMHA:

- Adult Mental Health and Habilitation (AMHH) – See the [Division of Mental Health and Addiction Adult Mental Health and Habilitation Services](#) module.
- Behavioral and Primary Healthcare Coordination (BPHC) – See the [Division of Mental Health and Addiction Behavioral and Primary Healthcare Coordination Services](#) module.
- Child Mental Health Wraparound (CMHW) – See the [Division of Mental Health and Addiction Child Mental Health Wraparound Services](#) module.

## ***Medicaid Rehabilitation Option Services***

The IHCP reimburses for authorized Medicaid Rehabilitation Option (MRO) services for members with mental illness when the provider for those services is an enrolled mental health center that meets applicable federal, state, and local laws concerning the operation of community mental health centers (CMHCs). MRO services include community-based mental healthcare for individuals with serious mental illness, youth with serious emotional disturbance, and individuals with substance use disorders.

MRO services may include clinical attention in the member's home, workplace, mental health facility, emergency department, or wherever needed. A qualified mental health professional, as outlined in 405 IAC 5-21.5-1(c), must render these services.

For more information about MRO services, see the [Medicaid Rehabilitation Option Services](#) module.

## Section 3: Managed Care Programs

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The State has mandated a managed care delivery system for Indiana Health Coverage Programs (IHCP) members enrolled in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. In each program, members are assigned to a managed care entity (MCE). Each MCE maintains its own provider and member services units.

Member enrollment in managed care is effective on the 1st or 15th calendar day of a month, with some exceptions, particularly for newborns born to MCE members. Managed care enrollment may be confirmed by any of the Eligibility Verification System (EVS) options described in the [Eligibility Verification System](#) section.

A member-requested change from one MCE to another is effective on the first day of the month. MCE changes are completed by the enrollment broker during a member's Open Enrollment period or as a just cause.

### Primary Medical Providers

As part of the managed care enrollment process, MCEs are responsible for assisting members with selection of a primary medical provider (PMP). See the *Healthy Indiana Plan, Hoosier Care Connect, and Hoosier Healthwise Provider Enrollment* section of the [Provider Enrollment](#) module for a list of IHCP provider specialties that are eligible to enroll as a PMP.

### Self-Referral Services

Most services in managed care require referral from a PMP. Self-referral services are an exception. The MCE reimburses any IHCP-enrolled providers for the following self-referral services unless other parameters are indicated:

- Chiropractic services rendered by a licensed chiropractor within chiropractic scope of practice
- Podiatry services rendered by a licensed podiatrist or physician
- Eye care services (except surgical services) rendered by a licensed optometrist or physician
- Routine dental services rendered by a licensed dental provider *within the MCE's network*
- Diabetes self-management training (DSMT) services
- Immunizations
- Family planning services
- Emergency services, as defined in *Indiana Code IC 12-15-12-0.3* and *IC 12-15-12-0.5*  
(*Note: Services may be rendered by **any** qualified provider, but for non-IHCP-enrolled providers, retroactive enrollment is required to facilitate payment.*)
- Urgent care services
- Psychiatric services rendered by any IHCP-enrolled provider licensed to provide psychiatric services within their scope of practice

- Behavioral health services, such as mental health, substance abuse treatment, and chemical dependency services rendered by any of the following providers within the MCE's network:
  - Outpatient mental health clinics
  - Community mental health centers (CMHCs)
  - Psychologists
  - Certified psychologists
  - Health service providers in psychology (HSPPs)
  - Certified social workers
  - Certified clinical social workers
  - Psychiatric nurses
  - Independent practice school psychologists
  - Advanced practice registered nurses, under *IC 25-23-1-1(b)*, credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  - Persons holding a master's degree in social work, marital and family therapy, or mental health counseling (for outpatient mental health services as defined under *Indiana Administrative Code 405 IAC 5-20-8*)

*Note: PMP referral is not the same as prior authorization. Contact the member's MCE to determine whether the service or procedure requires prior authorization. Self-referral services may be subject to benefit limitations; providers should contact the MCE for additional guidance.*

## Carved-Out Services

Claims for services provided under the managed care delivery system are submitted to the MCE in which the HIP, Hoosier Care Connect, or Hoosier Healthwise member is enrolled (or to vendors contracted by that entity). However, certain services are “carved out” of the managed care programs.

Carved-out services for managed care members are the financial responsibility of the State. These carved-out services are billed as fee-for-service (FFS) claims and are submitted to and processed, directly or indirectly, by DXC or, for pharmacy claims, OptumRx. Carved out services that require prior authorization are submitted to the FFS PA contractor, Cooperative Managed Care Services (CMCS) or, for pharmacy PA, to OptumRx.

Carved-out services include the following:

- Services provided by a school corporation as part of a student's Individualized Education Program (IEP)
- Medicaid Rehabilitation Option (MRO) services  
*(Note: MCEs must provide care coordination services and associated services related to MRO services including, but not limited, to transportation.)*
- Crisis intervention services
- First Steps services
- The following pharmacy services:
  - Hepatitis C drugs
  - Cystic fibrosis drugs Kalydeco, Orkambi, and Symdeko
  - Exondys 51
  - Spinraza

- Designated physician-administered drugs, listed in Physician-Administered Drugs Carved Out of Managed Care and Reimbursable Outside the Inpatient Diagnosis-Related Group, accessible from the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers)
- 1915(i) State Plan Home and Community-Based Services (HCBS), provided through the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA), including:
  - Adult Mental Health and Habilitation (AMHH) services
  - Behavioral and Primary Healthcare Coordination (BPHC) services
  - Child Mental Health Wraparound (CMHW) services

## Excluded Services

In addition to certain services being carved out of the managed care program, some services are *excluded* from managed care, and members must be disenrolled or suspended from managed care and moved to a fee-for-service program when they qualify for such services. Examples include:

- Psychiatric residential treatment facility (PRTF) services
- Long-term care services in a nursing facility (NF) or an intermediate care facility for individuals with intellectual disability (ICF/IID)
- 590 Program services
- 1915(c) HCBS waiver or Money Follows the Person (MFP) demonstration grant services, including:
  - Aged and Disabled (A&D) Waiver services
  - Traumatic Brain Injury (TBI) Waiver services
  - Community Integration and Habilitation (CIH) Waiver services
  - Family Supports Waiver (FSW) services

## Healthy Indiana Plan

HIP is a program sponsored by the state of Indiana that provides an affordable healthcare choice to thousands of individuals throughout Indiana. HIP provides health insurance for adults ages 19 through 64 whose income is at or under 138% of the federal poverty level (FPL), who are not on Medicare, and who do not qualify for another Medicaid program. HIP is a managed care program with vision and dental services, when applicable, carved into the managed care arrangement. Indiana offers HIP members a comprehensive benefit package through a deductible health plan paired with a personal healthcare account called a Personal Wellness and Responsibility (POWER) Account (sometimes referred to as a PAC). HIP comprises the following distinct benefit plans:

- **HIP Plus:** All HIP-eligible members are initially given the opportunity for coverage under the *HIP Plus* enhanced benefit package. *HIP Plus* participation requires members to make monthly POWER Account contributions, except for individuals exempt from cost-sharing. Member eligibility in *HIP Plus* is not final until either the first POWER Account or Fast Track prepayment is paid. To remain fully eligible for *HIP Plus*, members must continually make monthly POWER Account contributions.
- **HIP Basic:** HIP members with income at or below 100% FPL who do not make a Fast Track prepayment or initial POWER Account payment, or who fail to make subsequent monthly POWER Account payments, are not eligible for *HIP Plus*, and are transferred to the *HIP Basic* benefit plan. *HIP Basic* requires the member to make copayments at the point of service for each service received from a provider. Copayments for services received range from \$4 to \$8 for a doctor visit or prescription filled, and may be as high as \$75 for inpatient hospitalization. *HIP Basic* does not cover vision, dental, or chiropractic services. Formulary for pharmacy is limited in the *Basic* plan.

- *HIP State Plan Plus*: The following HIP members qualify for *HIP State Plan Plus*:
  - *Section 1931*-eligible parents and caretaker relatives eligible under *24 CFR 435.110*
  - Low-income 19- and 20-year-old dependents eligible under *42 CFR 4.35.222*
  - Individuals determined to be eligible for transitional medical assistance by the State in accordance with *Section 1925* of the *Social Security Act*
  - Individuals determined to be medically frail (see the [Medically Frail Individuals](#) section)

HIP members with this benefit plan have the same cost-sharing requirements as *HIP Plus* – they must make monthly POWER Account contributions, and they only have copayments on nonemergency use of the hospital emergency department. (Members who are American Indian/Alaska Natives are not required to make copayments or financial contributions to a POWER Account).

- *HIP State Plan Plus Copay*: This benefit plan is available to members with an income between 100% and 133% FPL, who were eligible under *HIP State Plan Plus* due to a determination of being medically frail, and who fail to make ongoing financial contributions to a POWER Account. Under this benefit plan, members receive full State Plan (Package A) benefits but are required to pay copays. Additionally, unpaid POWER Account payments accrue as debt to the member for each month they are enrolled in *HIP State Plan Plus Copay*.

*HIP State Plan Basic*: This benefit plan is available to members with income at or below 100% FPL, who were eligible under *HIP State Plan Plus*, and who fail to make financial contributions to a POWER Account. This plan offers access to all benefits available under the State Plan. Members with this benefit package have the same cost-sharing requirements and copayments for all services as *HIP Basic* members.

- *HIP Maternity*: This benefit plan offers access to all benefits available under the State Plan, with no cost-sharing, to pregnant women who are enrolled in or determined eligible for HIP. During the member's pregnancy and for a 60-day postpartum period, *HIP Maternity* offers enhanced benefits including vision, dental, and chiropractic services; nonemergency transportation; and enhanced smoking cessation services.

For more information about HIP and applying for benefits, see the [HIP website](#) at [in.gov/fssa/hip](http://in.gov/fssa/hip) or call 1-877-GET-HIP9. Applicants may select an MCE on the application or one will be auto-assigned, if not already assigned for the current calendar year. HIP applicants must also be assigned to a primary medical provider (PMP). The MCE will assist with the PMP assignment. Applicants who are not already assigned a current calendar-year MCE are able to change MCEs before their Fast Track payment or before their first POWER Account contribution is made. After payment, HIP members are not be able to make MCE changes until the annual MCE selection period (November 1 through December 15), unless they have an unresolved just-cause issue. Members will start with their newly selected MCE the first day (January 1) of the following year.

If a \$10 Fast Track prepayment was not made at the time of application, the selected MCE sends the applicant an invoice for the payment. HIP applicants have 60 days from the date on the invoice to make either a Fast Track payment or their first POWER Account contribution to be enrolled in *HIP Plus*.

Individuals approved for HIP who are still in the initial 60-day payment period and who have not yet paid their Fast Track payment or first POWER Account contribution are referred to as *conditionally eligible*. These individuals do not become fully eligible, nor enrolled as a member, until one of the following occurs:

- Fast Track payment (if Fast Track eligible)
- Payment of their first POWER Account contribution
- The expiration of the 60-day payment period (for individuals at or below 100% FPL)



Coverage for *HIP Plus* begins on the first day of the month in which the Fast Track payment or initial monthly POWER Account contribution was paid. Coverage may occur in a different month from that in which payment was made in the following situations:

- If the member was previously covered under a different Medicaid category (for example, Family Planning or Presumptive Eligibility) and is transitioning to HIP
- If the member was not Fast Track eligible (did not complete redetermination)
- If the member paid an MCE that he or she was not assigned to

Individuals who choose not to make their initial contribution will remain conditionally eligible and will be unable to receive coverage for services while they are conditionally eligible. If no payment has been made when the 60-day payment period expires, one of the following occurs:

- Individuals with income at or below 100% of the FPL will be enrolled in *HIP Basic*, with coverage effective the first day of the month in which the 60th day occurs.
- Individuals with income over 100% of the FPL will not be enrolled. They will need to reapply to receive HIP coverage.

## Member Eligibility for HIP

Eligibility for HIP is limited to Indiana residents ages 19 through 64 whose family income is up to 133% of the FPL. A 5% income disregard is applied to determine eligibility if an individual is found ineligible at 133% FPL but would be income-eligible with the disregard. Individuals with Medicare do not qualify.

The following categories of individuals are eligible to receive **HIP State Plan benefits**:

- Section 1931 eligible parents and caretaker relatives eligible under *Code of Federal Regulations 42 CFR 435.100*
- Low-income 19- and 20-year-old dependents
- Members determined eligible for transitional medical assistance by the State in accordance with Section 1925 of the *Social Security Act*
- Individuals deemed to be medically frail, as defined by *42 CFR 440.315(f)*

HIP-eligible pregnant women receive full State Plan benefits under *HIP Maternity* without cost-sharing obligations. All other HIP members eligible for State Plan benefits are enrolled in *HIP State Plan Plus* or *HIP State Plan Basic*, and are subject to the same cost-sharing components as *HIP Plus* or *HIP Basic* members, through either a POWER Account contribution or copayments.

## Pregnant Women

Pregnant applicants with income at or below 138% of the FPL and who meet all other HIP eligibility criteria will be enrolled in the *HIP Maternity* benefit plan, which provides full State Plan benefits, free of cost-sharing obligations.

*Note: Pregnant applicants with income **above** 138% of the FPL and eligible for IHCP services will be enrolled in Hoosier Healthwise, with **Package A – Standard Plan** coverage, which provides the same benefits as **HIP Maternity**.*

If a woman is already enrolled in HIP when she becomes pregnant, her coverage will be converted to the *HIP Maternity* benefit plan beginning the first of the month following notification of pregnancy, and will continue under that benefit plan until her postpartum coverage period is over. The postpartum coverage period lasts at least 60 days from pregnancy termination date. HIP members retain coverage through the HIP program, under their existing MCE, during pregnancy and at redetermination as long as they continue to meet eligibility requirements.

Pregnant applicants enrolling in HIP may also be determined eligible for retroactive coverage for up to 3 months prior to their application date. If the applicant is eligible for retroactive coverage, the IHCP EVS will indicate *Package A – Standard Plan* as the member’s coverage during the retroactive time period, with no enrolling MCE indicated. Retroactive coverage is paid through the FFS delivery system. See the [Retroactive Member Eligibility](#) section for more information.

## Medically Frail Individuals

Within the HIP-eligible population, the IHCP identifies those members who may be medically frail and provides enhanced coverage for those individuals who meet the medically frail criteria. HIP-eligible medically frail individuals are enrolled in one of the *HIP State Plan* options and receive comprehensive State Plan benefits equivalent to Package A benefits, including nonemergency transportation to medical appointments.

Federal regulation 42 *CFR* 440.315(f) defines the *medically frail* as individuals with one or more of the following:

- Disabling mental disorder
- Chronic substance abuse disorder
- Serious and complex medical condition
- Physical, intellectual, or developmental disability that significantly impair the individual’s ability to perform one or more activities of daily living
- Disability determination based on Social Security Administration (SSA) criteria

Each MCE is responsible for identifying and verifying all its members who are medically frail. However, members with a disability determination based on SSA criteria or members who are confirmed by the Indiana State Department of Health to have human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) are automatically confirmed medically frail by the State. The MCE is not responsible for verifying the medically frail designation of the members identified as such by the State, and these HIP members automatically qualify for enrollment into *HIP State Plan* benefits.

MCEs verify through claims or supplemental information utilizing the Milliman Medical Underwriting Guidelines to determine whether members qualify as medically frail. Members with a qualifying condition will be assessed by their MCE to verify that the condition is active and to determine how well the condition is controlled, as well as to identify any complicating comorbidities. Those members designated medically frail as a result of the MCE’s assessment will be enrolled in the *HIP State Plan* option the first day of the following month after the assessment is sent to the State.

Like all HIP-eligible individuals, medically frail HIP members will be enrolled with one of the HIP MCEs and required to contribute to a POWER Account or make copayments. Medically frail members will be enrolled in *HIP State Plan Plus* if they make their Fast Track payment or monthly POWER Account contribution. Members at or below 100% FPL who do not make their monthly contributions will be enrolled in *HIP State Plan Basic*. Although medically frail individuals are exempt from being locked out of the program for nonpayment of POWER Account contributions, those with incomes higher than 100% of the FPL who do not make their required contributions will continue to owe their required POWER Account contribution amounts and will also incur additional costs in the form of copayments until their owed contribution amount has been paid. The EVS identifies coverage during this time as *HIP State Plan Plus Copay*.

## ***Personal Wellness and Responsibility Account and Copayments***

All HIP members, except *HIP Maternity* members and American Indian or Alaska Native members, have a POWER Account. The POWER Account is modeled in the spirit of a traditional Health Savings Account (HSA) and is funded with State and member contributions. Employers and other third parties (such as nonprofit organizations and family members) may also contribute some or all of the member's POWER Account contribution. Members use POWER Account funds to meet the \$2,500 deductible. POWER Accounts are funded with post-tax dollars and are not considered HSAs or other health spending accounts (for example, Flexible Spending Accounts or Health Reimbursement Accounts) under federal law. POWER Accounts are not subject to regulation under the U.S. Tax Code, as such.

The POWER Account comprises a monthly member contribution plus a State contribution. Members pay a monthly contribution for *HIP Plus* coverage. HIP POWER Account contribution amounts are tiered and based on FPL percentage ranges and will not exceed 5% of the member's annual household income. In the case where two members are married, the combined total of both spouses' required POWER Account contributions cannot exceed 2% of the monthly household income. The maximum combined total annual amount of the POWER Account is \$2,500 and is used to pay the initial eligible expenses or the deductible to participating providers. If a POWER Account is not fully funded, the MCE is still required to pay all claims. A member's monthly POWER Account contribution is determined using the criteria shown in Table 3:

**Table 3 –Member's Monthly POWER Account Contribution Requirements  
Based on Income**

Yearly Income	Monthly POWER Account Contribution	
	Single Individual	Spouses (Each)
Up to and including 22% of the FPL	\$1.00	\$1.00
Above 22% of the FPL and up to and including 50% of the FPL	\$5.00	\$2.50
Above 50% of the FPL and up to and including 75% of the FPL	\$10.00	\$5.00
Above 75% of the FPL and up to and including 100% of the FPL	\$15.00	\$7.50
Above 100% of the FPL and up to and including 133% of the FPL	\$20.00	\$10.00
<i>Note: Beginning in January 2019, members may be assessed a 50% tobacco use surcharge in addition to the POWER Account tier amounts listed in this table.</i>		

Members enrolled in *HIP Basic* or *HIP State Plan Basic* are not required to make monthly contributions to their POWER Account, but are required to make copayments, which are assessed as one payment per type of service, per provider, per day (or one payment per inpatient stay). See Table 4 for applicable copayment amounts. Designated preventive care services (see *IHCP Bulletin* [BT201969](#)), are excluded from the copayment requirement.

Table 4 – Copayment Requirements for *HIP Basic*, *HIP State Plan Basic*, and *HIP State Plan Plus Copay*

Service	Copayment
Preventive care (including Early Periodic Screening, Diagnostic, and Testing [EPSDT] services for 19- and 20-year-old members)	No copayment
Medical services	\$4
Outpatient services	\$4
Inpatient services	\$75
Preferred drugs	\$4
Nonpreferred drugs	\$8
Nonemergency use of the emergency room	\$8 (except for individuals who call the MCE 24-hour nurse hotline before using the ER, for whom the copayment is then waived)

### Covered Services

HIP coverage is focused on preventive services and covers essential medical services, similar to commercial plans. All preventive services set forth in federal regulations will be administered free of cost sharing and will not be debited from the POWER Account. If additional preventive services are offered, the first \$500 of these services do not require member contributions from the POWER Account.

Table 5 lists categories of services and indicates whether *HIP Basic*, *HIP Plus*, *HIP State Plan*, and *HIP Maternity* include benefits within each category.

For information about provider billing and reimbursement for services delivered to HIP members, contact the member's MCE. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

Table 5 – HIP Benefit Comparison by Plan

Services	<i>HIP Basic</i>	<i>HIP Plus</i>	<i>HIP State Plan or HIP Maternity</i>
Ambulatory patient services	Yes	Yes	Yes
Bariatric surgery	No	Yes	Yes
Behavioral health services	Yes	Yes	Yes
Chiropractic services	No	Yes (6 spinal manipulations per calendar year)	Yes (50 units per calendar year)
Chronic disease management	Yes	Yes	Yes
Dental services	No	Yes	Yes
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, as defined at 42 USC 1396d(r), for 19- and 20-year-old members	Yes	Yes	Yes
Emergency services	Yes	Yes	Yes
Hospitalization	Yes	Yes	Yes

<b>Services</b>	<b>HIP Basic</b>	<b>HIP Plus</b>	<b>HIP State Plan or HIP Maternity</b>
Laboratory services	Yes	Yes	Yes
Maternity services	Yes	Yes	Yes
Medicaid Rehabilitation Option (MRO) services	No	No	Yes
Mental health services	Yes	Yes	Yes
Nonemergency transportation services	No	No	Yes
Prescription drugs	Yes	Yes	Yes
Preventive and wellness services	Yes	Yes	Yes
Rehabilitative and habilitative services and devices	Yes (60 combined outpatient therapy visits *)	Yes (75 combined outpatient therapy visits*)	Yes
Services that are not medically necessary	No	No	No
Substance use disorder services	Yes	Yes	Yes
Temporomandibular joint (TMJ) treatment (surgical and nonsurgical)	No	Yes	Yes
Urgent care	Yes	Yes	Yes
Vision services	No	Yes	Yes
Any other services not approved by the Centers for Medicare & Medicaid Services (CMS) in the specified benefit plan	No	No	No
* Outpatient therapy limits are for the combined total of physical therapy, occupational therapy, speech therapy, cardiac rehabilitation, and pulmonary rehabilitation visits annually.			

## Hoosier Care Connect

Hoosier Care Connect is a risk-based managed care program designed to improve the quality of care and clinical outcomes for members eligible for the IHCP on the basis of age, blindness, or disability. Hoosier Care Connect members pick an MCE and a primary doctor. The MCE assists members in coordinating their healthcare benefits and tailoring the benefits to individual needs, circumstances, and preferences. Hoosier Care Connect members receive full Medicaid State Plan benefits, in addition to care coordination services and other FSSA-approved enhanced benefits developed by the MCEs.

Individuals in the following groups who meet eligibility criteria (including income guidelines, when applicable) and who do not reside in an institution, are not receiving services through a home and community-based services (HCBS) waiver, and are not enrolled in Medicare will be enrolled in Hoosier Care Connect:

- Aged individuals (age 65 and over)
- Blind individuals
- Disabled individuals
- Individuals receiving Supplemental Security Income (SSI)
- Individuals enrolled in Medicaid for Employees with Disabilities (M.E.D. Works)

Children who fit the following descriptions may opt out of Traditional Medicaid (FFS) and voluntarily enroll in Hoosier Care Connect:

- Wards of the State
- Foster children
- Former foster children who turned 18 years of age while in foster care, are under age 26 (or under age 21, if the foster care was outside of Indiana), and opt out of Hoosier Care Connect
- Children receiving adoption assistance

Individuals will be removed from the Hoosier Care Connect program and transitioned to another IHCP program if they:

- Become eligible for Medicare
- Enter a nursing home for a length of stay greater than 30 days
- Enter a state psychiatric facility, a psychiatric residential treatment facility (PRTF), or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)
- Become eligible for and choose to enter an HCBS waiver program

## Hoosier Healthwise

The Hoosier Healthwise program provides coverage for children and for pregnant women who earn too much to qualify for HIP (138% FPL) but remain Medicaid eligible by having family income under 208% FPL.

Hoosier Healthwise assignment is **mandatory** for aid categories that include children and children who are eligible for the Children's Health Insurance Program (CHIP), unless they are a member of an exempted group. The specific eligibility aid category (based on household income/size) determines the benefit package.

The following IHCP members are **excluded from mandatory** assignment to Hoosier Healthwise managed care:

- Individuals in nursing homes and other institutions, such as PRTFs and ICFs/IID
- Individuals receiving psychiatric treatment in a state hospital
- Immigrants who qualify for Emergency Services Only (Package E) coverage
- Individuals receiving HCBS waiver services
- Individuals who are eligible for and opt to receive IHCP hospice services
- Members with HCBS waiver liability or end-stage renal disease (ESRD) waiver liability
- Members eligible for the Family Planning Eligibility Program

Table 6 explains the Hoosier Healthwise benefit packages.

Table 6 – Hoosier Healthwise Benefit Package Explanation

Benefit Package	Coverage
Package A	Full coverage for eligible children and pregnant women
Package C	Preventive, primary, and acute care services for eligible children

The Division of Family Resources (DFR) determines whether an applicant is approved for eligibility in Hoosier Healthwise. The member may choose an MCE on the application. After the DFR approves an applicant's eligibility, the member will immediately be assigned to the MCE that was chosen on the application or, if no MCE was chosen, to an MCE that is automatically selected for that member.

*Note: Enrollment for newborns whose mothers are enrolled in Package A with an MCE on the date of delivery is retroactive, with the mother's MCE, to the newborn's date of birth.*

Upon enrollment with an MCE, the member begins a 90-day "free change" period. During the free change period, the member may change from one MCE to another for any reason. When the free change period ends, the member remains with his or her chosen MCE for 9 months and may not move to another MCE except for reasons that meet the standard of *just cause*. *Just cause* reasons include:

- Lack of access to medically necessary services covered under the MCE's contract with the State
- Service not covered by the MCE for moral or religious objections
- Related services required to be performed at the same time
  - Not all related services are available within the MCE's network, and the member's PMP or another provider determines
  - that receiving the services separately would subject the member to unnecessary risk
- Lack of access to providers experienced in dealing with the member's healthcare needs
- Concerns over quality of care
  - Poor quality of care includes failure to comply with established standards of medical care administration and significant language or cultural barriers.
- Member's PMP disenrollment from member's current MCE
  - If a member's PMP disenrolls from the member's current MCE and reenrolls into a new MCE, the member can change plans to follow his or her PMP to the new MCE.

During the annual redetermination period, members may choose a different PMP within their selected MCE.

## ***Package A***

Hoosier Healthwise *Package A – Standard Plan* coverage encompasses the full array of Medicaid State Plan benefits for children and pregnant women who meet the following guidelines:

- **Pregnant women:** 139% – 208% FPL
- **Children (under age 19):** Under 158% FPL

Package A members do not have copayment or other cost-sharing requirements to receive covered healthcare services.

IHCP applicants determined eligible for Hoosier Healthwise Package A may also be determined eligible for retroactive coverage for up to 3 months prior to their application date. With the exception of newborns whose mothers were enrolled with a managed care assignment on the date of the child's birth, members determined retroactively eligible under a Hoosier Healthwise aid category are covered through the FFS delivery system during the retroactive period. See the [Retroactive Member Eligibility](#) section for more information.



## Package C

Hoosier Healthwise *Package C – Children’s Health Plan (SCHIP)* provides preventive, primary, and acute healthcare coverage to children who meet the following eligibility criteria:

- The child must be younger than 19 years old.
- The child’s family income must be between 158% and 250% of the federal poverty level.
- The child must not have creditable health coverage or have had creditable health coverage at any time during a waiting period lasting no longer than 90 days.
- The child’s family must financially satisfy payment of monthly premiums.

Package C members fall under the State Children’s Health Insurance Program (SCHIP).

## Enrollment Process and Cost-Sharing Requirements

A child determined eligible for Package C is made conditionally eligible pending a premium payment. The child’s family must pay a monthly premium, as shown in Table 7. After the first premium is paid, eligibility information is transferred to *CoreMMIS*.

Table 7 – Hoosier Healthwise Package C Premium Comparison

Income (As a Percentage of the Federal Poverty Level)	Monthly Premiums	
	One Child	Two or More
151% through 175%	\$22	\$33
176% through 200%	\$33	\$50
201% through 225%	\$42	\$53
226% through 250%	\$53	\$70

Enrollment continues as long as premium payments are received and the child continues to meet all eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 60-day grace period.

Package C members may be eligible for coverage no earlier than the first day of the month that the *Indiana Application for Health Coverage* was received. Package C members do not have retroactive eligibility, unless they are determined retroactively eligible for coverage under a **different** eligibility category or package, as described in the [Limited Retroactive Eligibility for Hoosier Healthwise Package C Members](#) section.

The child’s family may also be required to make copayments for ambulance transportation and pharmacy services. Providers are responsible for collecting copayments, and the copayment amount is deducted from the claim. Specific information about Package C member copayments is included in the [Service-Specific Copayment Policies](#) section of this module.

## Coverage and Limitations

Children enrolled in Package C are eligible for the following benefits:

- Ambulance transportation
- Anesthesia
- Certified nurse-midwife services
- Chiropractic services
- Clinic services

- Diabetes self-management training
- Dental services
- Early intervention services
- Food supplements, nutritional supplements, and infant formulas
- Home health services
- Hospice (under fee-for-service only)\*
- Hospital services
- Inpatient rehabilitative services
- Laboratory services
- Radiology services
- Medical supplies and equipment
- Mental health and substance abuse services
- Physicians' surgical and medical services
- Podiatry services
- Prescription drugs
- Therapies
- Vision services

*\*Note: Hospice is a covered benefit for Package C members, but the member must be disenrolled from managed care and enrolled in Traditional Medicaid to receive IHCP hospice services. See the [Hospice Services](#) module for more information.*

The following services have coverage limitations and policies under Hoosier Healthwise Package C that differ from those limitations required by Hoosier Healthwise Package A:

- *Emergency ambulance transportation* – Package C is covered for emergency ambulance transportation, subject to the prudent layperson standard as defined in 405 IAC 13-8-1. This service is subject to a \$10 copayment.
- *Nonemergency ambulance transportation* – Ambulance service for nonemergencies between medical facilities is covered when requested by a participating physician. A \$10 copayment applies. All other nonemergency transportation is not covered for Package C.
- *Chiropractic services* – Coverage is limited to five visits and 14 therapeutic physical medicine treatments per member per year. An additional 36 treatments may be covered if prior authorization (PA) is obtained based on medical necessity.
- *Early intervention services* – Package C covers immunizations and initial and periodic screenings according to the EPSDT/HealthWatch periodicity and screening schedule (see the [Early and Periodic Screening, Diagnostic, and Treatment \(EPSDT\)/HealthWatch Services](#) module). Coverage of referral and treatment services is subject to the Package C benefit limitations.
- *Inpatient rehabilitative services* – Coverage is available for a maximum of 50 days per calendar year.
- *Medical supplies and equipment* – Coverage is available for a maximum benefit of \$2,000 per year and \$5,000 per lifetime per member.

- *Podiatry services* – Surgical procedures involving the foot (which may include laboratory or x-ray services and hospital stays) are covered when medically necessary.
- *Prescription drugs* – The pharmacists provide a brand-name drug only when the prescribing physician writes **Brand Medically Necessary** on the prescription. The generic equivalent of a brand name drug will be substituted if one is available and the substitution results in a lower price. The medication should be dispensed as written; the pharmacist must dispense the drug prescribed. Pharmacy copayments for members enrolled in Hoosier Healthwise Package C continue to be \$3 for generic drugs and \$10 for brand name drugs.
- *Therapies* – Physical, speech, occupational, and respiratory therapy are covered for a maximum of 50 visits per year per type of therapy.

*Note: The MCEs may have different PA requirements and should be contacted for specific information.*

## Wraparound Services

Children enrolled in Hoosier Healthwise, including children enrolled in Package C, may be eligible for additional health coverage from the following programs:

- *Indiana First Steps* – This program provides early intervention services including:
  - Screenings and assessments
  - Planning and service coordination
  - Therapeutic services
  - Support services
  - Information and communication to infants and toddlers who have disabilities or who are developmentally vulnerable
- *Children's Special Health Care Services (CSHCS) at ISDH* – The CSHCS program provides healthcare services for children through age 21 who have a severe chronic medical condition that:
  - Has lasted or is expected to last at least 2 years
  - Will produce disability, disfigurement, or limits on function
  - Requires a special diet or devices
  - Would produce a chronic disabling condition without treatment

Both programs require the assistance of healthcare professionals to identify children for assessment and diagnostic evaluations, and to provide diagnoses and referrals. Additional information about the programs may be obtained by calling First Steps at 1-800-545-7763 or accessing the [First Steps](#) web page at [in.gov/fssa](http://in.gov/fssa) and by calling CSHCS at 1-800-475-1355 or accessing the [CSHCS website](#) at [in.gov/isdh](http://in.gov/isdh).

## Billing Procedures

The billing procedures for Package C are the same as those for the other Hoosier Healthwise benefit plans.

Even though children enrolled in Hoosier Healthwise Package C should not have other minimal essential coverage, providers are required to bill all other insurance carriers prior to billing the IHCP if additional insurance coverage is discovered.

## Hoosier Healthwise Package Comparison

Table 8 compares benefit packages of the Hoosier Healthwise program. The following items apply throughout the table:

- Package A covered services and limitations are cited in *405 IAC 5*; Package C covered services and limitations are cited in *405 IAC 13*. See the [Indiana Administrative Code \(IAC\)](#) page at in.gov.
- Covered services not reimbursed by MCEs are covered and reimbursed for Hoosier Healthwise members under fee-for-service (FFS) reimbursement, unless otherwise indicated in Package A and C.

Table 8 – Comparing Hoosier Healthwise Benefit Packages A and C

Benefit	Reimbursed by MCE	Package A	Package C
Applied Behavior Analysis (ABA) Therapy ( <i>405 IAC 5-22</i> )	Yes	Coverage is available for members under the age of 21 diagnosed with an autism spectrum disorder. Services must be provided in accordance with the State Plan and the IAC.	Coverage is available for members diagnosed with an autism spectrum disorder. Services must be provided in accordance with the IAC.
Behavioral Health (Mental Health and Substance Use Disorder Treatment) Services – Outpatient* ( <i>405 IAC 5-20-8</i> )	Yes (Except MRO services, which are reimbursed FFS; self-referral)	Coverage includes outpatient mental health and substance use disorder services (including partial hospitalization services), as defined in <i>405 IAC 5-20-8</i> , provided by physicians, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as health services providers in psychology (HSPPs). Limited to one evaluation and five psychotherapy visits per year without prior authorization. MCEs are responsible for methadone treatment provided in a clinic setting.	Unless otherwise provided by <i>IC 12-17.6-4-2</i> , outpatient mental health and substance use disorder services are covered subject to the same coverage policies and benefit limitations as apply to Package A. MCEs are responsible for methadone treatment provided in a clinic setting.

Benefit	Reimbursed by MCE	Package A	Package C
Behavioral Health (Mental Health and Substance Use Disorder Treatment) Services – Inpatient** (Freestanding Psychiatric Facility or Psychiatric Unit of an Acute Care Hospital) (405 IAC 5-20)	Yes	<p>Coverage includes inpatient mental health and substance use disorder services in a <u>psychiatric unit</u> of an <u>acute care hospital</u> or in a certified psychiatric hospital with <b>16 beds or fewer</b>.</p> <p>For members under 21 years of age (or under 22 and began inpatient psychiatric services immediately before their 21st birthday), coverage includes inpatient mental and behavioral health services in an institution of mental disease (IMD) with <b>more than 16 beds</b>.</p> <p>MCEs may authorize coverage for <i>short-term</i> stays for members 21–64 years of age an IMD in lieu of services or settings covered under Indiana’s Medicaid State Plan.</p>	Unless otherwise provided by <i>IC 12-17.6-4-2</i> , inpatient mental health and substance use disorder services are covered subject to the same coverage policies and benefit limitations as applied under Package A.
Behavioral Health (Mental Health and Substance Use Disorder Treatment) Services – Inpatient** (State Psychiatric Hospital) (405 IAC 5-20-1)	No	<p>Covered for individuals under age 21 if in a certified wing.</p> <p><b>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</b></p>	<p>Unless otherwise provided by <i>IC 12-17.6-4-2</i>, inpatient mental health and substance use disorder services are covered subject to the same coverage policies and benefit limitations as apply to Package A.</p> <p><b>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</b></p>
Chiropractic Services* (405 IAC 5-12)	Yes (Self-referral)	Coverage is available for covered services provided by a licensed chiropractor. Reimbursement is limited to a total of 50 office visits or treatments per member per year, which includes a maximum reimbursement of no more than five office visits per member, per year. For example, a chiropractor may bill for a maximum of five visits and 45 treatments (5 + 45 = 50), but may not bill for 50 treatments and five visits (50 + 5 = 55).	Coverage is available for covered services provided by a licensed chiropractor. Reimbursement is limited to five visits and 14 therapeutic physical medicine treatments per member per year. An additional 36 treatments may be covered if prior authorization is obtained based on medical necessity. There is a 50-treatment limit per year.
Chronic Disease Management	Yes	Coverage is available to qualified members with chronic diseases such as congestive heart failure, diabetes, and asthma, to enhance, support, or train on self-management skills.	Coverage is available to qualified members with chronic diseases such as congestive heart failure, diabetes, and asthma to enhance, support, or train on self-management skills.

Benefit	Reimbursed by MCE	Package A	Package C
Dental Services (405 IAC 5-14)	Yes (Routine dental services are self-referral within the member's MCE network)	Coverage for members age 21 and older includes dental services as described in 405 IAC 5-14. For children under age 21, all medically necessary dental services are covered, even if the service is not otherwise covered under Package A. No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.	All medically necessary dental services are provided for children enrolled in Package C, even if the service is not otherwise covered under CHIP. No orthodontic procedures are approved except in cases of craniofacial deformity or cleft palate.
Diabetes Self-Management Training Services* (405-IAC 5-36)	Yes (Self-referral)	Coverage is limited to 16 units per member, per year. Additional units may be prior authorized.	Coverage is limited to 16 units per member, per year. Additional units may be prior authorized.
Drugs – Prescribed (Legend) (405 IAC 5-24)	Yes (except drugs indicated in the <a href="#">Carved-Out Services</a> section, which are reimbursed as FFS)	Covers legend drugs if the drug is: <ul style="list-style-type: none"> <li>• Approved by the U.S. Food and Drug Administration (FDA)</li> <li>• Not designated by the Centers for Medicare &amp; Medicaid Services (CMS) as less than effective or identical, related, or similar to a less than effective drug or terminated</li> <li>• Not specifically excluded from coverage by the IHCP</li> </ul>	Covers legend drugs if the drug is: <ul style="list-style-type: none"> <li>• Approved by the U.S. FDA</li> <li>• Not designated by the CMS as less than effective or identical, related, or similar to a less than effective drug or terminated</li> <li>• Not specifically excluded from coverage by the IHCP</li> </ul>
Drugs – Over-the-Counter (Nonlegend)	Yes	Covers nonlegend (over-the-counter) drugs on the MCE formularies. Formularies are available from the MCE websites listed on the <a href="#">Pharmacy Services</a> page at in.gov/medicaid/providers.	Covers nonlegend (over-the-counter) drugs on the MCE formularies. Formularies are available from the MCE websites listed on the <a href="#">Pharmacy Services</a> page at in.gov/medicaid/providers.
Early Intervention Services (EPSDT) (405 IAC 5-15)	Yes (Immunizations are self-referral)	Covers comprehensive health and development history, comprehensive physical exam, appropriate immunizations, laboratory tests, health education, vision services, dental services, hearing services, and other necessary healthcare services from birth through the month of the member's 21st birthday, as described in the <a href="#">EPSTD/HealthWatch Services</a> module).	Covers immunizations and initial and periodic screenings as described in the <a href="#">EPSTD/HealthWatch Services</a> module. Coverage of treatment services is subject to the Package C benefit plan coverage limitations.

Benefit	Reimbursed by MCE	Package A	Package C
Emergency Services (IC 12-15-12-15 and IC 12-15-12-17)	Yes (Self-referral)	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.	Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. All medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition are covered.
Eye Care, Eyeglasses, and Vision Services (405 IAC 5-23)	Yes (Self-referral, except for surgical services)	Coverage for the initial vision care examination is limited to one examination per year for a member under 21 years of age, and one examination every 2 years for a member 21 years of age or older, unless more frequent care is medically necessary.  Coverage for eyeglasses, including frames and lenses, is limited to a maximum of one pair per year for members under 21 years of age and one pair every 5 years for members 21 years of age and older.  Exceptions are when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen, or broken beyond repair.	Vision care examination is limited to one examination per year, unless more frequent care is medically necessary.  Coverage for eyeglasses, including frames and lenses, is limited to a maximum of one pair per year, except when a specified minimum prescription change makes additional coverage medically necessary or the member's lenses and/or frames are lost, stolen, or broken beyond repair.



Benefit	Reimbursed by MCE	Package A	Package C
Family Planning Services and Supplies	Yes (Self-referral)	<p>Family planning services include:</p> <ul style="list-style-type: none"> <li>Limited history and physical examination</li> <li>Pregnancy testing and counseling</li> <li>Provision of contraceptive pills, devices, and supplies</li> <li>Education and counseling on contraceptive methods</li> <li>Laboratory tests, if medically indicated as part of the decision-making process for choice of contraception</li> <li>Diagnosis and treatment of sexually transmitted diseases (STDs) and sexually transmitted infections (STIs)</li> <li>Screening and counseling of members at risk for human immunodeficiency virus (HIV), and referral and treatment</li> <li>Tubal ligation</li> <li>Vasectomies</li> <li>Hysteroscopic sterilization with an implant device (Essure)</li> <li>Cytology (Pap tests) and cervical cancer screening, including high-risk human papillomavirus (HPV) DNA testing, if performed according to the United States Preventative Services Task Force guidelines</li> </ul>	<p>Family planning services include:</p> <ul style="list-style-type: none"> <li>Limited history and physical examination</li> <li>Pregnancy testing and counseling</li> <li>Provision of contraceptive pills, devices, and supplies</li> <li>Education and counseling on contraceptive methods</li> <li>Laboratory tests, if medically indicated as part of the decision-making process for choice of contraception</li> <li>Diagnosis and treatment of STDs and STIs</li> <li>Screening and counseling of members at risk for HIV and referral and treatment</li> <li>Tubal ligation</li> <li>Vasectomies</li> <li>Hysteroscopic sterilization with an implant device (Essure)</li> <li>Cytology (Pap tests) and cervical cancer screening, including high-risk HPV DNA testing, if performed according to the United States Preventative Services Task Force guidelines</li> </ul>
Federally Qualified Health Centers (FQHCs) (405 IAC 5-16-5)	Yes	Coverage is available for medically necessary services provided by licensed healthcare practitioners.	Coverage is available for medically necessary services provided by licensed healthcare practitioners.
Food Supplements, Nutritional Supplements, and Infant Formulas** (405 IAC 5-24-9)	Yes	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.	Coverage is available only when no other means of nutrition is feasible or reasonable. Not available in cases of routine or ordinary nutritional needs.

Benefit	Reimbursed by MCE	Package A	Package C
Hospital Services – Inpatient* (405-IAC 5-17)	Yes	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	Inpatient services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Hospital Services – Outpatient* (405 IAC 5-17)	Yes	Outpatient hospital services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.	Outpatient hospital services are covered when such services are provided or prescribed by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition.
Home Health Services** (405 IAC 5-16)	Yes	Home health coverage is available for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.	Home health coverage is available for medically necessary skilled nursing services provided by a registered nurse or licensed practical nurse; home health aide services; physical, occupational, and respiratory therapy services; speech pathology services; and renal dialysis for home-bound individuals.
Hospice Services** (405 IAC 5-34)	No	Hospice is available under Traditional Medicaid if the recipient is expected to die from illness within 6 months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. <b>Member must be disenrolled from Hoosier Healthwise managed care and enrolled in Traditional Medicaid (FFS) before hospice benefits can begin.</b>	Hospice is available under Traditional Medicaid if the recipient is expected to die from illness within 6 months. Coverage is available for two consecutive periods of 90 calendar days followed by an unlimited number of periods of 60 calendar days. <b>Member must be disenrolled from Hoosier Healthwise managed care and enrolled in Traditional Medicaid (FFS) before hospice benefits can begin.</b>
Laboratory and Radiology Services (405 IAC 5-18 and 405 IAC 5-27)	Yes	Coverage is available for medically necessary laboratory and radiology services, when ordered by a physician.	Coverage is available for medically necessary laboratory and radiology services, when ordered by a physician.
Long-Term Acute Care Hospitalization ** (See the <a href="#">Inpatient Hospital Services</a> module)	Yes	Long-term acute care services are covered. An all-inclusive per diem rate is paid based on level of care.	Long-term acute care services are covered up to 50 days per calendar year. An all-inclusive per diem rate is based on level of care.

Benefit	Reimbursed by MCE	Package A	Package C
Medical Supplies and Equipment (includes prosthetic devices, implants, hearing aids, dentures, and so forth)** (405 IAC 5-19)	Yes	Coverage is available for medical supplies, equipment, and appliances suitable for use in the home when medically necessary.	Covered when medically necessary. Maximum benefit of \$2,000 per year or \$5,000 per lifetime for durable medical equipment. Equipment may be purchased or leased, depending on which is more cost efficient.
Medicaid Rehabilitation Option (MRO) – Community Mental Health Centers * (405 IAC 5-22-1)	No; reimbursed FFS	Coverage includes community-based mental healthcare services (such addiction counseling, behavioral health counseling and therapy, and case management), for members with serious mental illness, youth with serious emotional disturbance, and individuals with substance use disorders. See the <a href="#">Medicaid Rehabilitation Option Services</a> module for details.	Coverage includes community-based mental healthcare services (such addiction counseling, behavioral health counseling and therapy, and case management), for members with serious mental illness, youth with serious emotional disturbance, and individuals with substance use disorders. See the <a href="#">Medicaid Rehabilitation Option Services</a> module for details.
Nurse Midwife Services (405 IAC 5-22-3)	Yes	Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.	Coverage of certified nurse-midwife services is restricted to services that the nurse-midwife is legally authorized to perform.
Nurse Practitioner Services (405 IAC 5-22-4)	Yes	Coverage is available for medically necessary services or preventative healthcare services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.	Coverage is available for medically necessary services or preventative healthcare services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification.
Nursing Facility Services – Long-Term** (405 IAC 5-31-1, see the <a href="#">Long-Term Care</a> module)	No	Long-term care nursing facility services require preadmission screening for LOC determination.  <b>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</b>  For a maximum of 60 days prior to LOC determination, coverage is available under managed care.  Coverage includes room and board, nursing care, medical supplies, durable medical equipment, and transportation.	Noncovered

Benefit	Reimbursed by MCE	Package A	Package C
Nursing Facility Services – Short-Term (405 IAC 5-31-1)	Yes	<p>The MCE may obtain services for its members in a nursing facility setting on a short-term basis (fewer than 30 consecutive calendar days). This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.</p> <p>Coverage includes room and board, nursing care, medical supplies, durable medical equipment, and transportation.</p> <p><i>Note: MCEs may be responsible for payment for up to 60 calendar days for members placed in a long-term care facility while the level of care determination is pending, allowing the member to be transitioned to FFS coverage.</i></p>	Noncovered
Nursing Facility Services – Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) – Long-Term** (405 IAC 5-13-2; see the <a href="#">Long-Term Care</a> module)	No	<p>Long-term ICF/IID services require preadmission screening for LOC determination.</p> <p><b>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</b></p> <p>For a maximum of 60 days prior to LOC determination, coverage is available under managed care.</p> <p>Coverage includes room and board, mental health services, dental services, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services.</p>	Noncovered.

Benefit	Reimbursed by MCE	Package A	Package C
Nursing Facility Services – Intermediate Care Facilities for Individuals with Intellectual Disability (ICFs/IID) – Short-Term** (405 IAC 5-31-1)	Yes	<p>The MCE may obtain services for its members in a nursing facility setting on a short-term basis (fewer than 30 consecutive calendar days). This may occur if this setting is more cost-effective than other options and the member can obtain the care and services needed in the nursing facility. The MCE can negotiate rates for reimbursing the nursing facilities for these short-term stays.</p> <p>Coverage includes room and board, mental health services, dental, therapy and habilitation services, durable medical equipment, medical supplies, pharmaceutical products, transportation, and optometric services.</p> <p><i>Note: MCEs may be responsible for payment for up to 60 calendar days for members placed in a long-term care facility while the level of care determination is pending, allowing the member to be transitioned to FFS coverage.</i></p>	Noncovered
Occupational Therapy* (405 IAC 5-22)	Yes	<p>Occupational therapy services must be ordered by the member's PMP or by another physician as part of an inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or assistant.</p> <p>PA is not required for initial evaluations or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge (not to exceed 30 units for any combination of therapies).</p>	<p>Occupational therapy services must be ordered by the member's PMP or by another physician as part of an inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or assistant.</p> <p>Services are covered only when determined to be medically necessary. Maximum of 50 visits per year (405 IAC 13-7-2), per type of therapy.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>Note: The maximum limit of therapy visits was removed for dates of service on or after January 1, 2020.</i></p> </div>
Organ Transplants** (405 IAC 5-3-13)	Yes	Coverage is in accordance with prevailing standards of medical care. Similarly situated individuals are treated alike.	Noncovered

Benefit	Reimbursed by MCE	Package A	Package C
Out-of-State Medical Services** (405 IAC 5-5)	Yes	Coverage is available for the following services provided outside Indiana: acute hospital care, physician services, dental services, pharmacy services, transportation services, therapy services, podiatry services, chiropractic services, durable medical equipment, and supplies. All out-of-state services are subject to the same limitations as in-state services.	Coverage is available for the following services provided outside Indiana: acute hospital care, physician services, dental services, pharmacy services, transportation services, therapy services, podiatry services, chiropractic services, durable medical equipment, and supplies. Coverage is subject to any limitations included in the Package C benefit package.
Physician Surgical and Medical Services* (405 IAC 5-25)	Yes	Coverage includes reasonable services provided by a doctor of medicine (MD) or doctor of osteopathy (DO) for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within scope of practice. PMP office visits are limited to a maximum of 30 per calendar year per member per provider without PA.	Coverage includes reasonable services provided by an MD or DO for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within scope of practice. PMP office visits are limited to a maximum of 30 per year per member without PA.
Physical Therapy* (405 IAC 5-22-6)	Yes	Physical therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or certified physical therapist assistant (PTA) under the direct supervision of a licensed physical therapist or physician. PA is not required for initial evaluations or for services provided within 30 calendar days following discharge from a hospital when ordered by a physician prior to discharge (not to exceed 30 units for any combination of therapies).	Physical therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care. Services must be provided by a licensed therapist or certified PTA under the direct supervision of a licensed physical therapist or physician. Services are covered when determined to be medically necessary. Maximum of 50 visits per year, per type of therapy.  <i>Note: The maximum limit of therapy visits was removed for dates of service on or after January 1, 2020.</i>
Podiatric Services (405 IAC 5-26)	Yes (Self-referral)	Laboratory services, x-ray services, hospital stays, and surgical procedures involving the foot are covered when medically necessary. No more than six routine foot care visits per year are covered.	Laboratory services, x-ray services, hospital stays, and surgical procedures involving the foot are covered when medically necessary. Routine foot care services are not covered.

Benefit	Reimbursed by MCE	Package A	Package C
Psychiatric Residential Treatment Facility (PRTF) ** (405 IAC 5-20-3.1)	No	<p>Reimbursement is available for medically necessary services provided to members younger than 21 years old in a PRTF.</p> <p>Reimbursement is also available for members younger than 22 years old who began receiving PRTF services immediately before their 21st birthday.</p> <p><b>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</b></p> <p>The FSSA will notify the MCE when an MCE's member is admitted to a PRTF. The MCE is required to provide case management and utilization management during the member's stay. The MCE is not at financial risk for PRTF services.</p>	<p>Reimbursement is available for medically necessary services provided to members younger than 21 years old in a PRTF.</p> <p><b>Member must be disenrolled from Hoosier Healthwise and enrolled in Traditional Medicaid for the benefit to begin.</b></p> <p>The FSSA will notify the MCE when an MCE's member is admitted to a PRTF. The MCE is required to provide case management and utilization management during the member's stay. The MCE is not at financial risk for PRTF services.</p>
Rehabilitation Unit Services – Inpatient** (405 IAC 5-32)	Yes	<p>The following criteria shall demonstrate the inability to function independently with demonstrated impairment: cognitive function, communication, continence, mobility, pain management, perceptual motor function, or self-care activities.</p>	Covered up to 50 days per calendar year.



Benefit	Reimbursed by MCE	Package A	Package C
Respiratory Therapy* (405 IAC 5-22)	Yes	<p>Respiratory therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a licensed respiratory therapist or certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic.</p> <p>PA is not required for inpatient or outpatient hospital, emergency, and oxygen in a nursing facility, for 30 calendar days following discharge from hospital when ordered by physician prior to discharge (not to exceed 30 units for any combination of therapies), and when ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, or upper respiratory infection (not to exceed 14 hours or 14 calendar days).</p>	<p>Respiratory therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a licensed respiratory therapist or certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic.</p> <p>Services are covered when determined to be medically necessary. Maximum of 50 visits per year (405 IAC 13-7-2), per type of therapy.</p> <div> <p><i>Note: The maximum limit of therapy visits was removed for dates of service on or after January 1, 2020.</i></p> </div>
Rural Health Clinics (RHCs)	Yes	Coverage is available for services provided by a physician; physician assistant; nurse practitioner; or appropriately licensed, certified, or registered therapist employed by the RHC.	Coverage is available for services provided by a physician; physician assistant; nurse practitioner; or appropriately licensed, certified, or registered therapist employed by the RHC.
Speech, Hearing and Language Disorders* (405 IAC 5-22)	Yes	<p>Speech-language therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a qualified therapist or assistant.</p> <p>PA is not required for initial evaluations or for services provided within 30 calendar days following discharge from a hospital when ordered by physician prior to discharge (not to exceed 30 units for any combination of therapies).</p>	<p>Speech-language therapy services must be ordered by the member's PMP or by another physician as part of a member's inpatient discharge plan of care or continuing plan of care and provided by a qualified therapist or assistant.</p> <p>Services are covered when determined to be medically necessary.</p> <p>Maximum of 50 visits per year, per type of therapy.</p> <div> <p><i>Note: The maximum limit of therapy visits was removed for dates of service on or after January 1, 2020.</i></p> </div>

Benefit	Reimbursed by MCE	Package A	Package C
Tobacco Dependence Treatment (405 IAC 5-37)	Yes (Except pharmacy benefits)	Reimbursement is available for tobacco dependence drug treatment and counseling services. Coverage of tobacco dependence counseling is limited to a maximum of 10 units per member per calendar year.	Reimbursement is available for tobacco dependence drug treatment and counseling services. Coverage of tobacco dependence counseling is limited to a maximum of 10 units per member per calendar year.
Transportation – Emergency (405 IAC 5-30)	Yes	Coverage has no limit or prior authorization requirement for emergency ambulance or trips to or from a hospital for inpatient admission or discharge, subject to the prudent layperson standard.	Covers emergency ambulance transportation using the prudent layperson standard. A \$10 copayment applies.
Transportation – Nonemergency (405 IAC 5-30)	Yes	Nonemergency travel is available for up to 20 one-way trips of less than 50 miles per year without PA.	Ambulance services for nonemergencies between medical facilities are covered when requested by a participating physician; a \$10 copayment applies. Any other nonemergency transportation is not covered.
Urgent Care Services	Yes (Self-referral)	Urgent care services are covered provided that they are medically necessary. Urgent care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.	Urgent care services are covered provided that they are medically necessary. Urgent care is needed for non-life-threatening emergencies that cannot wait for a normal scheduled office visit.
<p>* Prior authorization required under certain circumstances</p> <p>** Prior authorization always required</p> <p>Note: In general, all noncontracted, out-of-network providers require PA. Contracted, in-network providers must contact the MCE to determine whether PA is required.</p>			

## Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a risk-based managed care Medicare and Medicaid program that serves individuals who:

- Are 55 years old or older
- Are certified by their state to need nursing home care
- Are able to live safely in the community at the time of enrollment
- Live in a PACE service area (Contact local Area Agency on Aging [AAA] for guidelines.)

PACE participants are required to sign an enrollment agreement indicating they understand that the PACE organization must be their sole service provider. Services must be preapproved or obtained from specified doctors, hospitals, pharmacies, and other healthcare providers that contract with the PACE organization. Before providing services to a member, IHCP providers should always check the member's Medicare or IHCP card for a sticker indicating that the member is a PACE participant. The IHCP will deny payment of all fee-for-service claims submitted for PACE members.

PACE benefits include the following:

- Primary care
- Hospital care
- Medical specialty services
- Prescription drugs
- Nursing home care
- Emergency services
- Home care
- Physician, occupational, and recreational therapy
- Adult day care
- Meals
- Dentistry
- Nutritional counseling
- Social services
- Laboratory/x-ray services
- Social work counseling
- Transportation

## Section 4: Special Programs and Processes

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The Indiana Health Coverage Programs (IHCP) offers a variety of special programs and processes designed to serve special populations.

### Presumptive Eligibility

Presumptive Eligibility (PE) is an authorized IHCP process by which qualified providers (QPs) can determine individuals to be presumptively eligible, allowing them to receive temporary health coverage until the Family and Social Services Administration (FSSA) determines official eligibility.

For more information about PE process, including how to become a QP, see the [Presumptive Eligibility](#) module.

#### ***Presumptive Eligibility Coverage Period***

The PE coverage period begins on the day the QP determines an individual presumptively eligible for coverage. Services delivered prior to this date are not covered. For presumptive eligibility benefit plans that include inpatient hospital coverage:

- If a hospital admission date is before the presumptive eligibility start date, and the inpatient service is reimbursed using the diagnosis-related group (DRG) methodology, no portion of that member's inpatient stay will be considered a presumptive-eligibility-covered service.
- If a hospital admission date is before the presumptive eligibility start date, and the inpatient service is reimbursed on a level-of-care (LOC) per diem basis, dates of service on or after the member's presumptive eligibility start date will be covered.

If the PE member submits a completed *Indiana Application for Health Coverage* before the end of the month following the month in which his or her PE coverage began, then the PE coverage will last until the FSSA makes an official eligibility determination. PE coverage ends immediately when the FSSA determines the applicant to be denied for IHCP coverage. If determined eligible, PE coverage continues through the end of the month the eligibility decision is made.

If a PE member does **not** have a completed *Indiana Application for Health Coverage* pending with the FSSA by the last day of the month following the month in which his or her PE was established, the PE coverage will end on that date.

#### ***General Requirements for Presumptive Eligibility***

General applicant requirements for PE are as follows:

- Must be a U.S. citizen, qualified noncitizen, or a qualifying immigrant with one of the following immigration statuses:
  - Lawful permanent resident immigrant living lawfully in the United States for 5 years or longer
  - Refugee
  - Individual granted asylum by immigration office
  - Deportation withheld by order from an immigration judge
  - Amerasian from Vietnam
  - Veteran of U.S. Armed Forces with honorable discharge
  - Other qualified alien

- Must be an Indiana resident
  - An Indiana address must be provided on the application.
- Must not be a current IHCP member, including a member of HIP\*
  - Medical Review Team (MRT) and Preadmission Screening and Resident Review (PASRR) coverage are the only exceptions to this requirement; members with coverage under any *other* benefit plan are not eligible for PE.
  - Individuals who have recently applied for the IHCP but have not yet received a coverage determination may apply for PE to cover services while an IHCP decision is pending.
- Must not be enrolled in the PE process, currently or within time-frame restrictions\*
  - Individuals are allowed only one PE coverage period per rolling 12 months (or per pregnancy, for Presumptive Eligibility for Pregnant Women).
- Must not be currently incarcerated\*
- Must not be an adult (ages 21–64) who is admitted to or residing in an institute for mental disease (IMD)
- Must meet the income level, age, and any other requirements specific to certain aid categories

*\*Note: For exceptions specific to inmates, see the [Presumptive Eligibility for Inmates](#) section.*

## ***Presumptive Eligibility Aid Categories and Benefit Plans***

Aid categories eligible for PE include:

- Infants (under 1 year of age)
- Children (ages 1–18)
- Parents/caretakers
- Adults (ages 19–64, without Medicare)
- Pregnant women
- Former foster care children (ages 18–25)
- Individuals eligible for family planning services only

For details about income limits and other requirements specific to each aid category, see the [Presumptive Eligibility](#) module.

The benefit plan assigned during the PE period depends on the individual's aid category (with the exception of Medicaid Inpatient Hospital Services Only, which is assigned to presumptively eligible inmates regardless of their aid category). All presumptive eligibility benefit plans are provided under the fee-for-service (FFS) delivery system.

Table 9 – Presumptive Eligibility Benefit Plans and Coverage

PE Aid Category	Benefit Plan	Coverage Details
Infants	Presumptive Eligibility – Package A Standard Plan	All services available under Package A – Standard Plan (Medicaid State Plan services)
Children		
Parents/caretakers		
Former foster care children		
Pregnant women	Presumptive Eligibility for Pregnant Women	Ambulatory prenatal care services only (See the <a href="#">Presumptive Eligibility</a> module for details.)
Individuals presumptively eligible for family planning benefits only	Presumptive Eligibility Family Planning Services Only	Only services available under the Family Planning Eligibility Program (See the <a href="#">Family Planning Eligibility Program</a> section for details.)
Adults not eligible for another category	Presumptive Eligibility – Adult	Only services available under <i>Healthy Indiana Plan (HIP) Basic</i> , including copayment obligations (See the <a href="#">Healthy Indiana Plan</a> section for details.)
<b>PE for Inmates</b>	<b>Benefit Plan</b>	<b>Coverage Details</b>
Incarcerated individuals who are presumptively eligible, regardless of PE aid category	Medicaid Inpatient Hospital Services Only	Only inpatient services (See the <a href="#">Presumptive Eligibility for Inmates</a> section for details)

### ***Presumptive Eligibility for Inmates***

Presumptive Eligibility for Inmates (PE for Inmates) allows acute care hospitals that are PE QPs to enroll eligible inmates into the IHCP for temporary coverage of authorized inpatient hospitalization services. Coverage during the PE for Inmates period is identified as *Medicaid Inpatient Hospital Services Only*.

### **Requirements for PE for Inmates**

In addition to meeting all the general applicant requirements for PE (with the exception of requirements pertaining to incarceration, current IHCP coverage, and current or past PE coverage, as indicated in the [General Requirements for Presumptive Eligibility](#) section), individuals found presumptively eligible through the PE for Inmates process must also meet the following additional requirements:

- Be an inmate from an Indiana Department of Correction (IDOC) facility or county jail operating under the memorandum of understanding or contract with the Indiana Family and Social Services Administration (FSSA)
- Not be on house arrest (individuals under house arrest may be eligible under the regular PE process)
- Not be pregnant or admitted for labor and delivery
- Be admitted for inpatient hospitalization
- Be under the age of 65

## Coverage under PE for Inmates

The Medicaid Inpatient Hospital Services Only benefit plan provides coverage for inpatient services only. If an inmate's admission results from an emergency department visit, the physician services performed in the emergency department prior to admission can be reimbursed. In all other cases, services can be reimbursed only if they are provided between inpatient admission and discharge. The following are examples of services that may be covered for inmates hospitalized for at least 24 hours:

- Medically necessary physician services provided during the inpatient stay
- Medically necessary hospital services provided during the inpatient stay
- Medically necessary medications provided during the inpatient stay
- Medically necessary durable medical equipment (DME) provided during the inpatient stay

Any service provided on an outpatient basis, before inpatient admission or after discharge, will not be reimbursed. The following are examples of services that are not covered:

- Transportation that occurs before admission or after discharge
- Services provided in the emergency department if the visit does not result in an inpatient admission
- Medications or DME that are provided before inpatient admission or after discharge

For special billing instructions related to the Medicaid Inpatient Hospital Services Only benefit plan, see the [Claim Submission and Processing](#) module.

## Extended PE Coverage Period for Inmates

To retain inpatient benefits, inmates who go through the PE process must complete an *Indiana Application for Health Coverage*, with assistance from the correctional facility or county jail. Individuals who complete the full application and are confirmed eligible for PE for Inmates will continue to be covered under the Medicaid Inpatient Hospital Services Only benefit plan for 12 months. If the inmate does not complete an *Indiana Application for Health Coverage*, his or her Medicaid Inpatient Hospital Services Only coverage will end on the last day of the month following the month in which the individual was found presumptively eligible. If the individual remains incarcerated after 1 year, he or she may reapply for coverage through the PE for Inmates process.

## Medical Review Team

Individuals determined by the Social Security Administration to be disabled are considered disabled for Medicaid purposes. For all others, the DFR is responsible for determining initial and continuing eligibility for Medicaid disability. To meet the disability requirement, a person must have an impairment that is expected to last a minimum of 12 months.

The Medical Review Team (MRT) determines whether an applicant meets the Medicaid disability definition based on medical information that the DFR collects and provides to the MRT.

*Note: An individual receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) for his or her own disability automatically meets the State's disability requirement without requiring a separate disability determination by MRT.*



To make timely determinations about an applicant's alleged disability for coverage through the IHCP, the MRT directs providers to include medical reports that substantiate level of severity and functionality. The following examples represent expected information for the four most common application diagnoses:

- Back pain
  - Associated surgeries for back pain
  - Medications that the applicant is taking
  - Details about the applicant's level of functioning with the back pain
  - Any additional information about the applicant's back pain
- Depression
  - Associated hospitalizations for depression
  - Medications the applicant is taking
  - Details about the applicant's level of functioning with depression
  - Any additional information about the applicant's depression
- Diabetes
  - Associated neuropathy, nephropathy, or retinopathy
  - Blood sugar levels, HgA1C levels, and other relative lab results
  - Medications the applicant is taking
  - Diabetes flow sheet
  - Details about the applicant's level of functioning with diabetes
  - Additional information about the applicant's diabetes
- Hypertension
  - Associated end organ damage due to hypertension
  - Medications the applicant is taking
  - Details about the applicant's level of functioning with hypertension
  - Any additional information about the applicant's hypertension

See the [Claim Submission and Processing](#) module for MRT billing procedures.

## Right Choices Program

The Right Choices Program (RCP) is Indiana's Restricted Card Program. The goal of the RCP is to provide quality care through healthcare management, ensuring that the right service is delivered at the right time and in the right place for Healthy Indiana Plan (HIP), Hoosier Care Connect, Hoosier Healthwise, and Traditional Medicaid members who have been identified as using services more extensively than their peers. RCP members remain eligible to receive all medically necessary, covered services allowed by their existing benefit plans. However, services are reimbursed only when rendered by the member's assigned RCP lock-in providers or when rendered by a specialist who has received a valid, written referral from the member's primary RCP physician. See the [Right Choices Program](#) module for details about the RCP.

*Note: The Provider Healthcare Portal eligibility verification includes a Right Choices Detail panel for members assigned to the RCP. Users can expand this detail panel to view lock-in provider assignments.*

## Preadmission Screening and Resident Review

The Preadmission Screening and Resident Review (PASRR) process is a requirement for all residents of IHCP-certified nursing facilities. The screening identifies individuals who may have a mental illness (MI), intellectual disability/developmental disability (ID/DD), or mental illness and intellectual disability/developmental disability (MI/ID/DD).

PASRR coverage is identified in the EVS as PASRR Mental Illness (MI) or PASRR Individuals with Intellectual Disability (IID). Only providers contracted with the Division of Mental Health and Addiction (DMHA) or the Division of Disability and Rehabilitative Services (DDRS) can be reimbursed for PASRR services.

See the [Long-Term Care](#) module for more information about the PASRR process.

## Section 5: Member Copayment Policies

*Note: For specific copayment policies regarding services rendered to members enrolled in managed care plans, providers should contact the appropriate managed care entity (MCE). MCE contact information is included in the [IHCP Quick Reference Guide](#) available at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

### Overview

Some Indiana Health Coverage Programs (IHCP) members are required to contribute a copayment for certain services. The copayment is made by the member and collected by the provider at the time the service is rendered. The amount of the copayment is automatically deducted from the provider's payment; therefore, the provider should not subtract the copayment from the submitted charge.

According to *Code of Federal Regulations 42 CFR 447.15*, providers may not deny services to any member due to the member's inability to pay the copayment amount on the date of service. Pursuant to this federal requirement, this service guarantee does not apply to a member who is able to pay, nor does a member's inability to pay eliminate his or her liability for the copayment. It is the member's responsibility to inform the provider that he or she cannot afford to pay the copayment on the date of service. The provider may bill the member for copayments not paid on the date of service.

For fee-for-service (FFS) members, providers can determine the copayment amount due for a particular service on a particular date when verifying the member's eligibility through any of the Eligibility Verification System (EVS) options: Provider Healthcare Portal (Portal), 270/271 electronic transactions, or Interactive Voice Response (IVR) system. See the [Portal Copayment Response](#) section for examples of how the information appears on the Portal.

### Copayment Limitations and Exemptions

In accordance with federal regulations, IHCP members with cost-sharing obligations (such as copayments, contributions, premiums, deductibles, or other Medicaid-related charges) are not required to pay more than 5% of the family's total countable income toward these charges. The 5% calculation considers the total cost-sharing amounts paid by all members in the household against the total countable income for the household. The IHCP applies this limit based on calendar quarters: January–March, April–June, July–September, and October–December. (For Package C members, the 5% limitation applies on a yearly basis.)

Accordingly, copayment amounts will not be deducted from claims processed after the member's copayment obligation has been met in any given quarter. If a member's copayment obligation has been met for the quarter for fee-for-service (FFS) benefits, a copayment amount of \$0 will be indicated in the EVS for the member on that date of service. See the [Portal Copayment Response](#) section for an example. (For managed care benefits, providers will need to contact the MCE to determine whether the member's copayment obligation has been met for the quarter.)

Members in the following categories are exempt from cost-sharing obligations, including copayments:

- American Indian/Alaskan Native
- Under age 18, except for Package C members
- Pregnant
- Receiving hospice care
- Eligible for Medicaid due to a diagnosis of breast or cervical cancer

*Note: Members residing in an institution are exempt from **copayment** obligations but are responsible for paying any applicable **facility liability**.*

Members in exempt categories are not affected by the cost-sharing tracking process – they should never be charged copayments.

## Service-Specific Copayment Policies

Providers are advised to review the *Indiana Administrative Code* (IAC) for complete copayment narratives. The following services may require a copayment:

- Transportation (405 IAC 5-30-2)
- Pharmacy (405 IAC 5-24-7)
- Nonemergency services provided in an emergency room setting (405 IAC 1-8-4)

Additional services are subject to copay under certain Healthy Indiana Plan (HIP) benefit plans, as described in the [Personal Wellness and Responsibility Account and Copayments](#) section. Presumptive Eligibility Adult copayments mirror those of *HIP Basic*.

Table 10 provides copayment amounts at a glance for specific services provided to Traditional Medicaid, Hoosier Care Connect, and Hoosier Healthwise Package C members. The sections that follow provide additional information.

Table 10 – Service-Specific Copayments by Program

	Traditional Medicaid (Fee for Service)	Hoosier Care Connect	Hoosier Healthwise (Package C Only)
Nonemergency transportation	\$0.50–\$2 each way	\$1 each way	Noncovered
Emergency transportation	No copay	No copay	\$10
Pharmacy (generic)	\$3 per prescription	\$3 per prescription	\$3 per prescription
Pharmacy (brand name)	\$3 per prescription	\$3 per prescription	\$10 per prescription
Nonemergency use of the emergency room	No copay	\$3	No copay

## Transportation Services

For nonemergency transportation services, providers may collect a copayment from Traditional Medicaid members equal to the amount presented in Table 11.

Table 11 – Nonemergency Transportation Copayments for Traditional Medicaid

Copayment	Service
\$0.50 each one-way trip	Transportation services for which Medicaid pays \$10 or less
\$1 each one-way trip	Transportation services for which Medicaid pays \$10.01 to \$50
\$2 each one-way trip	Transportation services for which Medicaid pays \$50.01 or more
<p><i>Note: The determination of the member's copayment amount is to be based on the reimbursement for the base rate or loading fee only.</i></p> <p><i>No copayment is required for an accompanying adult (such as a parent) traveling with a minor member or for an attendant.</i></p>	

The nonemergency transportation copayment for Hoosier Care Connect members is \$1 each one-way trip, regardless of distance.

For both Traditional Medicaid and Hoosier Care Connect members, emergency ambulance services are exempt from copayments.

Hoosier Healthwise Package C members receive ambulance transportation services, subject to a \$10 copayment, in the following circumstances:

- Emergencies, subject to the prudent layperson definition of emergency in *405 IAC 11-1-6*
- Between medical facilities when ordered by the treating physician

All other transportation is not a covered service under Package C.

## Pharmacy Services

Traditional Medicaid and Hoosier Care Connect members are generally required to pay a \$3 copay for all prescription drugs. Pharmacy copayments for Package C members are \$3 for generic drugs and \$10 for brand name drugs.

For more detailed information about copayments for pharmacy services, see the [Pharmacy Services](#) module.

## Nonemergency Services Rendered in the Emergency Department

Hoosier Care Connect members are subject to a copayment of \$3 per date of service for nonemergency services rendered in an emergency department setting.

Family planning services are exempt from the copayment requirements for nonemergency services rendered in an emergency department.

## Portal Copayment Response

On the Portal, copayment information is displayed in the *Benefit Details* panel (see Figure 25).

Figure 25 – Copayment Information in the Portal

Benefit Details			
Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	02/14/2020	02/14/2020
Coverage	Description and Copayment Message	Copoly Amount	
Full Medicaid	Medical Care - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Chiropractic - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Dental Care - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Hospital - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Emergency Services - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Professional (Physician) Visit - Office - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Hospital - Inpatient - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Urgent Care - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Mental Health - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Vision (Optometry) - Copay is not applicable to this type of service.	\$0.00	
Full Medicaid	Medically Related Transportation - The copay amount for transportation services will range from \$0.50 to \$2.00 based on the allowed amount for the procedure code. Please see the IHCP provider reference modules for more details.	\$2.00	
Full Medicaid	Hospital - Outpatient - Copay applies only to non-emergency services.	\$3.00	
Full Medicaid	Pharmacy - The copay for Pharmacy services is \$3.00 for legend and non legend drugs and insulin for each covered drug dispense. Please refer to the Pharmacy Reference module for additional information on copay exemptions.	\$3.00	

When the member has met the quarterly cost-sharing obligation, the amount indicated in the Copay Amount column will change to \$0.00.

The copay amount may also display \$0.00 in situations where the amount owed is a range or when providers are required to check with the MCE for the specific amount of the copay. In these cases, the presence of a zero in the last column does not necessarily indicate that the member's cost-sharing obligation has been met. See Figure 26.



Figure 26 – Portal Response for Managed Care Benefit Plans That May Require a Copay

Benefit Details			
Coverage	Description	Effective Date	End Date
Package A-Standard Plan	Package A-Standard Plan	02/05/2020	02/05/2020
Coverage	Description and Copayment Message	Copay Amount	
Package A-Standard Plan	Chiropractic - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Dental Care - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Hospital - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Emergency Services - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Pharmacy - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Vision (Optometry) - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Mental Health - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	
Package A-Standard Plan	Urgent Care - The copay amount and coverage may vary. Please see the IHCP Provider Modules for copay details or contact the member's MCE for further information.	\$0.00	

If a member's benefit plan does not require copayments, the Portal message will indicate that copayments do not apply (see Figure 27).

Figure 27 – Portal Response for Benefit Plans That Do Not Require Copays

Benefit Details			
Coverage	Description	Effective Date	End Date
HIP Plus	HIP Regular Plus-No MRO services	02/05/2020	02/05/2020
Coverage	Description and Copayment Message	Copay Amount	
HIP Plus	Urgent Care - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	
HIP Plus	Chiropractic - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	
HIP Plus	Vision (Optometry) - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	
HIP Plus	Professional (Physician) Visit - Office - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	
HIP Plus	Pharmacy - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	
HIP Plus	Emergency Services - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	
HIP Plus	Hospital - Copay is not applicable to members in the HIP Regular Plus benefit plan.	\$0.00	





## Section 6: Benefit Limit Information

*Note: The information in this section pertains to fee-for-service coverage. For managed care members, providers must follow the managed care entity (MCE) procedures for obtaining benefit limit information.*

Some Indiana Health Coverage Programs (IHCP) services are subject to benefit limits, based on the number of units or dollar amount reimbursed within a given time frame. Before rendering such services, providers must verify that the member's benefit limit has not been met.

For details about service-specific benefit limits, refer to the provider reference module applicable to that type of service.

### Checking Benefit Limits on the EVS

Select member benefit limit information is available through Eligibility Verification System (EVS), which providers can access through any of the following methods, as described in the [Eligibility Verification System](#) section:

- [Provider Healthcare Portal](#), accessible from the home page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers)
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 electronic data interchange (EDI) transaction

The EVS response consists of a description of the limit (including the applicable explanation of benefits [EOB] code that would be returned with claim denials if the limit is exceeded), what the limit is (the dollar amount or number of units allowed for the particular service within the given time frame), and how much is remaining for that member. The amount remaining reflects FFS paid claims only, and does not include payment for claims that are still in process.

See Figure 28 for an example of the benefit limits returned using the Portal.

Figure 28 – Benefit Limit Details on the Portal

Limit Details		
The Dollar Limits and Service Limits may not reflect recent claims.		
Dollar Limits	Limit	Remaining
6113 DME LIMITED TO \$2000 PER MEMBER PER CAL YR	\$2,000.00	-
Service Limits	Limit	Remaining
6225 ONE SEALANT PER TOOTH PER LIFETIME - Sealant applied	3, 14, 19, 30	-
6830 TRANSPORT: ONE-WAY TRIP IN EXCESS OF 20/12 MONTHS	20	14

The system lists only services for which some reimbursement has been made. If the full amount is still remaining for a particular limit, that limit will not be displayed.

Not all benefit limits are tracked within the EVS. See Table 12 for a list of those limits that *are* returned by the EVS, as well as the associated EOB that would be returned if additional amounts were billed after the limit has been met. To avoid claim denials for the EOBs shown in Table 12, before rendering such services, providers should use the EVS to verify that the member has not exhausted the applicable benefit limits.

Table 12 – EOBs Related to Benefit Limit Information Available through the EVS

Limit Description	Corresponding EOB Description
6012 MEDICAL SERVICES 30 PER YEAR	Reimbursement is limited to 30 medical services per member per rolling calendar year, unless prior authorization for additional services has been obtained.
6054 ONLY ONE HEARING TEST PER 36 MO. WITHOUT PA	Audiological assessments are limited to once every 3 years per member. Prior authorization is required for payment of additional services
6060 SPEECH THERAPY EVALUATIONS/ONE PER YEAR	Reimbursement for speech evaluation is limited to once every twelve months. Prior authorization is required for payment of additional evaluations.
6085 INCONTINENCE SUPPLIES LIMITED \$1950/ROLLING YEAR	Incontinence supplies are limited to total dollar amount of \$1,950.00 per rolling 12 months
6090 PODIATRIST OFFICE VISITS LTD TO 1 PER 12 MO (DTL)	Indiana Medicaid benefits allow payment for one (1) podiatry office visit per recipient per calendar year.
6099 REIMBURSEMENT IS LIMITED TO 50 CHIROPRACTIC SVCS	Reimbursement is limited to no more than 50 chiropractic services per member per calendar year. These services could include up to five (5) office visits and spinal manipulation treatments, or physical medicine treatments.
6101 CHIROPRACTIC RESTRICTIVE OFFICE VISITS CODES (NP)	New patient chiropractic office visits are reimbursable once per provider per lifetime of the recipient.
6102 CHIROPRACTIC OFFICE VISITS LIMITED TO 5 PER YEAR	Indiana Health Coverage Programs reimbursement limited to five chiropractic office visits per year. This recipient has received the maximum number allowable. Prior authorization is required for payment of additional visits.
6105 ONE FULL SPINE X-RAY PER YEAR FOR CHIROPRACTOR	Indiana Health Coverage Program reimbursement is limited to one (1) full spinal x-ray per recipient per calendar year by a chiropractor. Maximum reimbursement has been paid. Prior authorization is required for payment of additional visits.
6111 CHIROPRACTIC OFFICE VISITS LIMITED TO FIVE PER YEAR	Reimbursement is limited to five chiropractic office visits per year per member. This member has received the maximum number allowable.
6112 MAX OF 14-CHIRO THERAPEUTIC PHYS MED TRT PER YR	Therapeutic physical medicine treatments are limited to 14 per member per calendar year. This member has received the maximum number allowable.
6113 DME LIMITED TO \$2000 PER MEMBER PER CAL YR	Durable medical equipment is limited to \$2,000 per member per calendar year. This member has received the maximum amount allowable
6114 DME LIMITED TO \$5000 PER MEMBER PER LIFETIME	Reimbursement for durable medical equipment is limited to \$5,000 per member per lifetime.
6115* PHYS THERAPY SVCS LIMIT 50 VISITS PER YR	Reimbursement is limited to 50 physical therapy treatments per member per calendar year. This member has received the maximum number allowable.

Limit Description	Corresponding EOB Description
6116* SPEECH THERAPY SVC LIMIT 50 VISITS PER YR	Reimbursement is limited to 50 speech therapy treatments per member per calendar year. This member has received the maximum number allowable.
6118* OT SVCS LTD TO 50 VISITS PER CAL YR	Reimbursement is limited to 50 occupational therapy treatments per member per calendar year. This member has received the maximum number allowable.
6119* INPT REHAB SVCS LIMIT 50 DAYS PER CALENDAR	Reimbursement is limited to 50 days of inpatient rehabilitation services per recipient per calendar year. This recipient has received the maximum number allowable.
6120 OP MNTL HLTH/SUBS ABUSE OV 30 / CAL YR W/O PA (DTL)	Reimbursement is limited to 30 visits for outpatient mental health/substance abuse services per recipient per calendar year without prior authorization. This recipient has received the maximum number allowable.
6121 OP MNTL HLTH/SUBS ABUSE OV 50 / CAL YR W/PA (DTL)	Reimbursement is limited to 50 visits maximum for outpatient mental health/substance abuse services per recipient, per calendar year, with prior authorization. This recipient has received the maximum number allowable.
6122 CHIROPRACTIC THERAPEUTIC PHYSICAL MEDICINE TREATME	Therapeutic physical medicine treatments exceeding fourteen (14), up to a maximum of fifty (50), per recipient, per calendar year, require prior authorization.
6195 FRAMES INITIAL OR REPAIR / REPLACEMENT 21 YRS OLDER	Frames initial or repair/replacement- member over 21 years of age
6196 FRAMES INITIAL / REPLACEMENT MEMBER 21 YRS YOUNGER	Frames initial or replacement- member 21 years or younger
6209 FULL MOUTH OR PANORAMIC X-RAYS LIMIT ONCE /3 YRS	Full-mouth or panorex x-rays limited to once every three years.
6211 PERIODIC/LIMITED ORAL EVAL LIMIT 1 EVERY 6 MONTHS	Periodic or limited oral evaluations are limited to one every 6 months.
6212 FLUORIDE TREATMENT LIMITED TO 1 EVERY 6 MONTHS	Indiana Health Coverage Program benefits allow payment for one topical application of fluoride every six (6) months. Fluoride treatments are limited to recipients 0 through 20 years of age.
6221 PERIODONTAL ROOT PLAN/SCAL 4 TX/2YRS NON-INSTITUTI	Reimbursement limited to four treatments of periodontal root planing/scaling every two (2) years for non-institutionalized recipients between the ages of three (3) and twenty (20) years.
6222 PERIODONTAL ROOT PLAN/SCALING, 4 TX PER 2 YRS INST	Reimbursement is limited to four treatments of periodontal root planing and scaling for institutionalized recipients every two (2) years regardless of age.
6223 PERIODONTAL ROOT PLAN 21 YR OR > 4/LIFE NON-INST	Periodontal root planing/scaling 4x/lifetime/non-institutional 21 years and older.

Limit Description	Corresponding EOB Description
6225 ONE SEALANT PER TOOTH PER LIFETIME	Indiana Health Coverage Program benefits allow payment for one sealant treatment per premolars and molars per lifetime.
6235 PROPHY & PERIODTL MAINT NON-INSTI 21> LIM 1/12 MOS	Prophylaxis and periodontal maintenance is limited to one treatment every 12 months for non-institutional members 21 years or older.
6244 D4355 LIMITED TO ONCE EVERY 3 YEARS (DTL)	D4355 [full mouth debridement to enable comprehensive evaluation and diagnosis] limited to once every 3 years.
6271 LENSES INITIAL/REPLACEMENT, MEMBER YOUNGER THAN 21	Lenses initial or replacement- member 21 year or younger
6272 LENSES INITIAL REPAIR/REPLACEMENT MEMBER 21 YRS	Lenses initial repair/replacement member over 21 years of age
6297 ROUTINE VISION EXAM LIMIT TO 1/12 MONTHS AGE 0-20	Routine vision exams limited to one (1) per twelve (12) months for ages 1 to 20 years.
6298 ROUTINE VISION EXAM AGE 21-999 LTD TO 1/24 MO (DTL)	Routine vision exams are limited to one (1) per twenty-four (24) months for ages twenty-one to 999 years.
6310 PROPHY & PERIODTL MAINT NON-INSTI 1-20 LIM 1/6 MOS	Prophylaxis and periodontal maintenance limited to one treatment every six months for non-institutionalized members over age twelve months to twenty-one years
6752 PT EVAL LTD TO 1 PER 12 MO W/O APPROVED PA (DTL)	Reimbursement is limited to one physical therapy evaluation per member per 12 months unless prior authorization has been obtained.
6753 OCCUPATIONAL THERAPY EVALUATION - 1 PER 12 MONTHS	Reimbursement is limited to one occupational therapy evaluation per member per 12 months unless prior authorization has been obtained.
6803 TRANSPORT: ONE-WAY TRIP IN EXCESS OF 20/12 MONTHS	Prior authorization required for transportation services in excess of the allowed number minus exemptions.
6855 MORE THAN 6 ROUTINE FOOT CARE TREATMENTS/12 MONTHS	Reimbursement is limited to six routine foot care services per year for patients with diabetes mellitus, peripheral vascular disease, or peripheral neuropathy, unless prior authorization has been obtained.
*Note: Limits marked with an asterisk will no longer be applied for dates of service on or after January 1, 2020.	

## Checking Benefit Limits via Written Correspondence

Not all benefit limits are tracked by the EVS. Additionally, the EVS may not include all the information that a provider needs to determine whether a member has exhausted a particular benefit – such as the dates the limits were exhausted. This situation can result in reduced reimbursement or no reimbursement for rendered services. Providers may submit secure correspondence through the Portal to inquire the date on which a particular member exceeded his or her service limitations. Providers should allow up to 4 business days for a response.

To assist analysts in researching the issue and providing a resolution, providers should clearly state the reason for the inquiry. The Written Correspondence Unit may contact the provider for additional information if needed.

Providers should not send inquiries to resubmit claims previously rejected.

To submit an inquiry through the Portal, providers can create a secure correspondence message using the Coverage Inquiry category. For information about registering to use the Portal and submitting secure correspondence via the Portal, see the [Provider Healthcare Portal](#) module.

## Calendar-Year Versus 12-Month Monitoring Cycle

Most IHCP benefit limits are monitored via a rolling 12-month period. However, some are monitored on a calendar-year basis. During claim processing, *CoreMMIS* reviews the claim history to ensure that services do not exceed established limits. *CoreMMIS* compares the service date for a particular claim with service dates that are already paid. *CoreMMIS looks back* at service dates within the particular code's established service limit. If the number of services or dollars has been exceeded for a specific benefit limit, prior authorization (PA) may be required based on medical necessity. If PA is not obtained, *CoreMMIS* rejects the claim. In summary, *CoreMMIS* generally *rolls back* 1 year from the service date and counts the number of units or dollars used. *CoreMMIS* calculates benefit limits on a service-date-specific basis for paid claims.

*Example 1:* This example illustrates a calendar-year monitoring cycle. IHCP members are authorized office visits at 30 per calendar year. A member became eligible on February 1, 2019, and with four office visits per month (to a physician, chiropractor, podiatrist, and mental health provider), reaches the 30-office-visit limitation in September 2019. Without PA, the member is not authorized for another office visit until January 1, 2020 (the beginning of a new calendar year), at which point the restriction of 30 visits per calendar year is restored.

*Example 2:* This example illustrates a rolling 12-month monitoring cycle. The IHCP limits coverage of mental health services provided in an outpatient or office setting to 20 units per member, per provider, per rolling 12-month period without prior authorization. A member became eligible on February 1, 2019, and received four units of outpatient mental health services on the first day of eligibility. On September 1, 2019, the member reached the 20-unit limitation. Without PA, the member is not authorized for another outpatient mental health service until February 1, 2020. In this example of a 12-month limitation, the system restores the four units depleted on September 1, 2019, 12 months (or 365 days) after the date they were used. In this illustration, if the member does not use another outpatient mental health service until all 20 units are restored, the full complement of 20 units per rolling 12-month period would be totally restored in September 2020.

The following services are limited on a **calendar-year** basis:

- Office visits
- Inpatient rehabilitation
- Durable medical equipment (DME) and home medical equipment (HME)
- Chiropractic
- Vision

The following services are limited on a **rolling 12-month** basis:

- Mental health visits
- Transportation
- Incontinence supplies

## Billing Members for Services that Exceed Benefit Limits

Providers may bill IHCP members for services exceeding the benefit limitations under the following circumstances:

- If the EVS indicates that the limitation has already been met, the provider should inform the member that the service will not be covered. If the member still wishes to receive the service, he or she may be asked to sign a waiver stating the service will not be covered because benefits have been exhausted and the member will be responsible for the charges.
- If the EVS does not indicate that benefits have been exhausted, the provider may ask the member or their guardian to attest in writing that they have not received the service in question within the applicable timeframe. The member is informed that, if he or she is misrepresenting and the provider's claim is denied for exceeding benefit limitations, the member will be responsible for the charges.

See the *Charging Members for Noncovered Services* section of the [Provider Enrollment](#) module for more information.

## Section 7: Retroactive Member Eligibility

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For many Indiana Health Coverage Programs (IHCP) members, eligibility may be established retroactively up to 3 months prior to the member's date of application, if the member met eligibility requirements in each of those retroactive months.

Exceptions include:

- Healthy Indiana Plan (HIP) members (other than *HIP Maternity* members) – Contact the member's managed care entity (MCE) for more information.
- Hoosier Healthwise Package C members – See the [Limited Retroactive Eligibility for Hoosier Healthwise Package C Members](#) section for more information.
- Qualified Medicaid Beneficiary (QMBs) benefits – Eligibility is effective no earlier than the month of application.

For these members, eligibility is effective no earlier than the month of application.

### Retroactive Eligibility for Managed Care Members

IHCP applicants determined eligible for Hoosier Care Connect, Hoosier Healthwise Package A, or *HIP Maternity* may also be determined eligible for retroactive coverage prior to their application date. Retroactive coverage for these members is provided through the fee-for-service (FFS) delivery system. The eligibility verification system (EVS) will indicate *Package A – Standard Plan* as the member's coverage during the retroactive time period, with **no** enrolling MCE indicated. For dates of service on and after the date eligibility was actually determined, the EVS will indicate the applicable benefit plan (such as *Package A – Standard Plan, Full Medicaid, or HIP Maternity*) **with** a managed care assignment.

The exception to this policy is newborns whose mothers were enrolled with a managed care assignment on the date of the child's birth. In this case, the baby is assigned to the mother's MCE, retroactively effective to the date of birth. The mother's and the baby's coverage remains with the MCE during the baby's retroactive period. After an IHCP Member ID is assigned to the baby, providers may send claims for the baby's care to the mother's MCE. Prior authorization (PA) for services may be required. Providers should check with the MCE about PA before submitting claims or retroactive PA requests.

For all other members, services rendered during the retroactive eligibility period must be billed through the FFS delivery system. Nonpharmacy claims should be submitted to DXC Technology; pharmacy claims should be submitted to OptumRx. For dates of service after the managed care member's retroactive eligibility period must be submitted to the MCE with which the member is enrolled.

### Limited Retroactive Eligibility for Hoosier Healthwise Package C Members

Members are given a *conditional approval* if they meet all Hoosier Healthwise Package C eligibility requirements except for payment of the first premiums. Members become eligible for Hoosier Healthwise Package C benefits on the first day of the month in which they applied; however, their enrollment does not become effective until the required first month's premium has been paid. For example, if an application was filed in June and was approved June 15, and the applicant's required first month's premium was paid in full for June, eligibility would begin on the first day of June.

Hoosier Healthwise Package C members are not eligible for coverage before the month in which they apply for benefits. However, these members may be determined eligible for retroactive coverage under *another*

category. If it is determined that a Package C member is retroactively eligible for another category, retroactive coverage can begin up to 3 months prior to the date of application, and providers that have rendered services to Package C members during the period of retroactive eligibility are bound by the requirements described in the [Provider Responsibilities for Retroactive Eligibility](#) section.

During this limited retroactive period, member benefits will be covered through the FFS delivery system as described in the previous section.

## Provider Responsibilities for Retroactive Eligibility

Providers rendering services to members during a period of retroactive eligibility are bound by the requirements that follow. **This policy is mandatory and applies only in instances where the provider was enrolled in the IHCP at the time the service was rendered.**

When notified of a member's retroactive eligibility, the provider must refund to the member any payments made by the member for IHCP-covered services rendered during the member's retroactive eligibility period. If a provider's office observes specific refund procedures, and those refund procedures apply to all customers regardless of patient status, then refunds to IHCP members should be handled in the manner dictated by normal office procedures. For example, an organization that routinely issues refunds at the end of the month and mails the refunds by check can apply the same process to IHCP members.

The provider must then bill the IHCP for the covered service rendered during the member's retroactive eligibility period. Nonpharmacy claims should be submitted to DXC Technology; pharmacy claims should be submitted to OptumRx.

If the service was rendered more than 180 days ago (or more than 1 year ago, for dates of service before January 1, 2019) and is past the filing limit, the provider must submit a paper claim with appropriate documentation requesting a filing limit waiver. The filing limit is waived if the claim is filed within 180 days of the date when the member was notified of his or her retroactive eligibility. Retroactive billing procedures are discussed in the [Claim Submission and Processing](#) module.

If prior authorization (PA) is required for the covered service, such authorization may be requested retroactively up to 180 days ago from the date the member was enrolled. The provider must indicate on the PA request or with a cover letter that the reason for the untimely request was due to retroactive eligibility. Authorization is determined solely on the basis of a medical necessity.

The following example illustrates retroactive enrollment:

An IHCP provider renders an IHCP-covered service on February 1, 2019, to a patient on a private-pay basis. On April 1, 2019, the patient is enrolled in the IHCP retroactively to November 1, 2018. The patient informs the provider and furnishes a member identification card. The provider verifies program eligibility using one of the EVS options. After member eligibility is verified, the provider refunds the full amount paid by the patient for the services rendered on February 1, 2019. The provider bills the IHCP before the August 1, 2019, timely filing limit (180 days after the date the member was retroactively enrolled). Providers must return money paid by the IHCP member as soon as possible, according to normal office policy. See the [Third-Party Liability](#) module when there is also a third-party carrier involved.



## Section 8: Member Appeals

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If a member disagrees with any action that denies or delays member services or benefits – whether taken by the Indiana Health Coverage Programs (IHCP), the county office of the Family and Social Services Administration (FSSA) Division of Family Resources (DFR), or a contractor – the member can ask for a hearing (pursuant to *Code of Federal Regulations 42 CFR 431.200 et seq.* and *Indiana Administrative Code 405 IAC 1.1*) by filing an appeal.

The process for appealing decisions about eligibility is listed on the notice applicants receive from the DFR.

Appeals must be submitted in writing. Guidance to members on how to submit an appeal is available from the [Member Appeals](#) page on the IHCP member website at [in.gov/medicaid/members](http://in.gov/medicaid/members).

Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members must contact their managed care entity (MCE) and work through their grievance process. MCE members must first exhaust their managed care remedies before submitting an appeal to the State.

All member requests for administrative hearings should include a letter stating the reason for appeal. The letter must be signed and must include the member's name and other important information, such as the dates of the decision. The request should be sent to the following address:

**Family and Social Service Administration  
Office of Hearings and Appeals  
402 W. Washington St., Room E034  
Indianapolis, IN 46204**

As an alternative, appeals regarding eligibility decisions can be sent to the [local DFR office](#).

All appeals must be filed within 33 calendar days of the date the adverse decision was received or takes effect, whichever is later. If the request is for a continuing service (for example, home healthcare), at least 10 days' notice plus 3 days' mailing time must be given before the effective date of the denial or modification, except as permitted under *42 CFR 431.213* and *42 CFR 431.214*. As required by statute, if the request for a hearing is received before the effective date of the denial or modification of continuing services, services are continued at the authorized level of the previous prior authorization (PA).

At the hearing, the member has the right to self-representation or to be represented by legal counsel, a friend, a relative, or another spokesperson of the member's choice. The member is given the opportunity to examine the entire contents of his or her case file, and any and all materials used by the FSSA, county office, or the contractor that made the adverse determination. Other IHCP and assistance benefits are not affected by a request for a hearing.